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A REPORT OF AN EPIDEMIC OF ACCUTE ANTERIOR POLIOMYELITIS.

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Acute anterior poliomyelitis is recognized as the cause of more infantile paralysis than any other known disease. It comes as a thief in the night, attacking the young and innocent, and although it does not leave the home empty, as the mortality is very low, it does leave an impress that time rarely overcomes. It is widespread, being found in both hemispheres, north and south, and it usually occurs during the hot months. With this last observation in view, it is of interest to find that in San Francisco, where the temperature is cool and equable, we still have our proportion yearly of acute infantile spinal paralysis, with an occasional outbreak of cases, sufficient in number, and within a limited period and locality, to warrant their being grouped as an epidemic.

In connection with the generally-accepted idea that the majority of these cases develop during the hot months, it may be worth noting that during the month of May, 1901, the temperature was lower, the humidity greater, and there was less sunshine than there had been for fifteen previous years in San Francisco, according to the Weather Bureau report. During this year (1901) the infection that causes acute anterior poliomyelitis was very lively in this state, it being most active, however, during the months of May and June. The little victims are to be found among all classes, the entire length of the state; at the seaboard towns, as well as in the interior; in the mountain districts, and again from the valleys. By far the greater proportion was in San Francisco and its immediate vicinity.

The following cases are reported, not as an exhaustive review of the whole number of persons afflicted, simply facts about a few who have been under observation, and who present a picture fairly typical of an epidemic of acute anterior poliomyelitis. The first twenty cases include those who were examined by Dr. Leo Newmark, at the San Francisco Polyclinic, with other patients who were brought to him during the prevailing epidemic, from the vicinity of San Francisco or from more distant localities. The remainder are selected from those at the hospital for children and from cases referred to Dr. H. M. Sherman and Dr. S. J. Hunkin in their orthopedic work. The first two cases are examples of paralysis of both upper and lower limbs, and, when once seen, this clinical picture is not easily forgotten.

Case 1. H. R., age 17 months. In July had spasms, after which he could not use his arms or legs. In a week or two he recovered the use of upper limbs completely. Status April 14, 1902: Both lower limbs still paralyzed, some slight extension of right toes and ankle, left foot dangles, and rotates right thigh inward. Swings left thigh at the hip, and has power over left flexors of knee. No knee-jerk obtained, right or left.

Case 2. L. DeN., age two and a half

years. A healthy child until June 15. He had a little fever, vomited frequently, and had spasms. This condition continued several days, when he was observed to be paralyzed in both upper and lower limbs. At the time of examination, Sept. 17, 1901, he was still limp and helpless in his legs and arms.

Case 3. W. M., age 15 months. After being feverish all night, this baby had a convulsion, with high fever, at 6 A. M., March 31. The following afternoon he was found to be paralyzed in the left leg, from his toes to the hip. Sensation preserved. Gradually improved. Status June 21, 1901: Left knee-jerk absent. Muscles below left knee all right. Flexes knee and hip normally. Stands with knee hyperextended; has a hip walk. Left gluteal muscles more flabby than right. Left adductors seem fair. Left extensors of knee respond fully to faradic current.

Case 4. F. F., age three years. On May 2 was taken suddenly ill with fever and convulsions. After a few days she could not use her right leg, and she complained of pain whenever the limb was touched. Almost a year after the onset, April 22, 1902, this little one is found to be greatly improved. There is still weakness in the anterior tibial, and paralysis of the posterior tibial group.

Case 5. F. R., age two and a half years. In June he had fever, with spasms. This condition lasted about a week, the child crying most of the time, as if he were in pain. Followed by paralysis of both legs. Aug. 15, 1902: He can move the toes of right leg. Paralysis of all the muscles below and above the knees. It will be observed that in these five cases the paralysis was preceded by convulsions; also worthy of note that the next baby, although subject to epileptic seizures, did not have an attack during onset of paralysis.

Case 6. S., age 10 months. Well-developed baby, brought up from Salinas with history of having had epilepsy since three months old. He was ill the early part of August, with vomiting and high fever, followed by paralysis of right leg. Status Sept. 4, 1901: Left leg normal, right knee-jerk absent; only movement in right extremity is plantar flexion of the toes.

Case 7. X., age 20 months. In the middle of June became very ill with high fever (105° Fahr.), which persisted for about two weeks, when he was found to be completely paralyzed in both arms. Status July 12, 1901: Left hand and wrist recovered, but there is paralysis of left upper arm, including elbow and shoulder. Total paralysis of right arm, upper and lower. This baby had a fracture of the radius near middle of right forearm a short time before the febrile sickness.

Case 8. O. H. Fell from a go-cart May 1, and supposed to have broken her right arm near the elbow. The arm was placed in splint for six weeks. There is an indefinite history of the child having some fever during this time. When the splint was removed from right arm, there was no motion above the elbow. March 8, 1902: A well-nourished, intelligent little girl, whose right arm is atrophied above the elbow and at the shoulder, with complete paralysis of deltoid, brachialis anticus, supinator longus, and, possibly, serratus magnus, infra and supra spinatus muscles. (The above case might be classed by some observers as an example of paralysis due to traumatism.)

Case 9. T., age 20 months. In June had some fever, followed by weakness in the right arm and leg. Could not use the arm for nearly four weeks. In the second week of October again ill with fever, when left foot became paralyzed. Status Dec. 22, 1901: Left foot dangles. Anterior tibial and peroneal group paralyzed. Plantar flexion of foot and toes probable, but not sure. Knee-jerks present. Electrical examination not complete, because the child was restless. Thigh and calf musculature responds to galvanic and faradic currents. There is no galvanic or faradic contraction in left nervus peroneus. Sluggish contraction—galvanic—is obtained of an extensor tendon, by placing the electrode near the left ankle. From right peroneus get extension and abduction of the right foot. Adduction by the tibialis anticus is lacking. This adduction also seems lacking when the foot is used. Right arm and forearm thinner than the left. Seems to use the arm freely. March 14, 1902: There is no movement in ankle or toes of left foot, neither flexion nor extension. Left leg atrophied and cold. Right tibialis muscle does not act. Can abduct right arm, but can not raise it to the vertical. Right deltoid feels flabby, and right arm is thinner than the other. Present condition, Jan. 19, 1903, obtained through the courtesy of Dr. H. M. Sherman: Arm almost entirely well. Muscles above knees fairly good. Right tibialis anticus and posticus and sural group paralyzed. Left soleus may be good. All the rest are paralyzed, except some of the short flexors of the left toes. The fact that in the above child there was a second invasion within the same year, although of rare occurrence, corresponds to the observation of others.

Case 10. Boy three and a half years, at Weaverville. In the first week of August was ill with fever and vomiting. By evening he was unable to move his right leg. Status October 11: In walking the right knee hyperextended, and he can not flex the knee, neither can he dorsi-flect the foot or toes, except the great toe. Left knee-jerk normal. Flexors of right knee do not react plainly to fairly strong galvanic and faradic currents, except the biceps, which does contract sluggishly. Posterior tibial group normal. Peronei react to galvanism and faradism. Extensors of knee show reduced contractility. Complete degeneration reaction in extensors of the foot, in the little toes, and in the tibialis anticus muscles. There were three other cases reported as having occurred at the same time as the above, within seven miles of Weaverville.

Case 11. W. L., age 18 months. Sudden invasion in June of high fever and vomiting, followed by absolute paralysis of the whole lower left limb. This condition gradually improved. Status Sept. 23, 1901: Movements at left hip perfect. He can not abduct or adduct the foot, neither can he dorsiflect the toes and ankle. Plantar flexion of the toes possible. Galvanic reduction and complete degeneration reaction in left tibialis anticus and left extensors of the toes. No contraction obtained in posterior tibial muscles by practicable currents.

Case 12. W. M., age two and three-quarter years. Period of invasion several days previous to April 26, when he became paralyzed in his right leg. Could not urinate for two days. No other involvement. Status May 7, 1901: Healthy child. Does not extend the toes or ankle; extends and flexes right knee. Right knee-jerk absent. Beginning degeneration reaction in right anterior tibial group. No faradic reaction. Peroneal group and tibialis posticus muscle normal. May 14: Walks with hyperextended right knee and drop-foot. Extends and flexes right knee freely; even extends the toes a little, not the foot. Right knee-jerk present, but less strong than left. June 18: Greatly improved. Right knee-jerk equal to left. Extends the toes well, and also the foot somewhat with abduction. September 17: Tibialis anticus paralyzed and whole leg atrophied.

Case 13. L. J., age two years. Peculiar onset of fever May 12, from which she recovered. One week later again taken very ill with high fever, and is said to have shaken (not spasms) day and night for three days. There was no loss of consciousness. Some weakness of legs, from which she recovered. On May 20 she had paralysis of right arm. Status June 17: Well-nourished child. Right arm and leg paralyzed. Very feeble extensor movements in thumb and fingers. Faradic current shows contractility of musculo-spiral (except supinator longus) and of long flexors of fingers. Thenar, hypothenar, deltoid, biceps, supinator longus, do not contract at a bearable strength.

Case 14. W. C., age two and a half years. June 12: Restless during night, with some fever, after which he could not walk for several weeks, because of weakness in left foot and ankle. Examination October 8: He walked limping; left knee-jerk lessened. All the muscles, except the left tibialis anticus and extensor longus digitorum, respond to the faradic current.

Case 15. C. B., age two and a half years, after a sudden mild onset at night was found to be unable to walk. He did not improve much for six months. One year later he walked limping, the paralysis involving muscles about the hip. There was no electrical examination made.

Case 16. C., age three and a half years, had been complaining of right leg for several weeks, especially of the big toe. June 26 had high fever and nausea; next day could not use right leg; hopped on left leg. June 28: Left leg affected; could not pass urine for one day. Status July 1: Well nourished; complains of pains when moved briskly. Holds his head somewhat retracted, but he can move it forward. Left lower extremity knee-jerk absent; can extend the leg a little, also dorsiflexes the ankle; but plantar flexion seems impaired. Right lower extremity knee-jerk absent. Motion less in all segments. No electrical examination, because of tenderness. Sensation perfect. This child said to have died August 28, 1901, of some digestive trouble.

Case 17. R. W., age 10½ years, after one day of fever (temperature 102), June 13, was paralyzed in left leg, below the knee. The next day the other leg was involved; then first one arm, then the other, was paralyzed, after the legs. Status July 8, 1901: Both lower limbs paralyzed and flaccid. Knee-jerks absent; both upper limbs involved, deltoids and also hands; movements at elbow partially preserved. Note that the paralysis came in successive days, first in the upper, then in the lower, extremities, beginning on the left side, and, too, that side was more completely involved.

Case 18. W. H., age two and a half years. On the 7th of May had a high fever, which continued three or four days. After that he could not walk. Frequent micturition, but without difficulty. Status May 28: Has all the movements at right knee, but does not move right ankle; right knee-jerk doubtful, left lively. No contraction in right muscles under practicable faradic current. Some contraction in calf muscles; no contraction in right extensor cruris; left muscles do not contract strongly. With galvanic current the anterior tibial muscles react sluggishly. June 11, 1901: Right and left knee-jerk normal; child stands with knee hyperextended, and drop-foot. Right tibialis anticus and extensor digit commununis muscles show complete degeneration reaction.

Case 19. W. B., age 12. A type of Landry's paralysis, which first involved the right lower extremity, then left lower, followed by paralysis of upper extremity, terminating in death on the evening of the sixth day. In the home of this child there were at the same time four others, three adults and a younger child, who complained of malaise in their lower limbs. Most observers mention the fact that during an epidemic of infantile spinal paralysis there is usually one or more of acute ascending paralysis. And, too, it has been noted that during these epidemics the ordinary diseases of childhood are attended with more marked nervous symptoms.

Case 20. G., age 34 years, after a trip to Mount Tamalpais and a few days spent in Mill Valley had some pain in his bladder, in his back, and sore feeling in his legs. In the course of a few days the legs were completely paralyzed. Bladder paralyzed, also the trunk, and the abdomen was extended. Finally the right upper limb became paralyzed, except the hand. The left arm was slightly weakened. Temperature 102° Fahr. for several days, also retention of urine four days. Later the right arm and trunk improved. Status November 18: Complete flaccid paralysis, with atrophy of both lower extremities, except slight plantar flexion of right toes. Knee-jerk absent. Weakness of right brachial triceps; sensation preserved; muscles not tender; optic discs normal.

Case 21. Boy, three years old, early in summer had sudden invasion, followed by total paralysis of right lower extremity. Status Jan. 19, 1903: Muscles atrophied above and below the knee. Hip muscles improved. He is able to walk unassisted.

Case 22. Same age and same locality,—San Rafael,—with less sudden invasion and more pain; had paralysis of whole lower left limb. Not much improvement to date; hip muscles involved.

Case 23. X., age four and a half years. Without any observed period of onset, the child commenced to limp, then dropped in the street. Right lower limb paralyzed.

Case 24. Age 15 months. In this case there is a history of pain and tenderness for two weeks before he developed paralysis in both lower limbs. Some improvement.

Case 25. Boy seven and one half years old, from near the same place as above,—Soledad,—had a left lower leg paralysis in March, 1901. (This case had been operated on with good results, tendo Achilles split and linked with anterior tibial group.)

Besides the above authentic cases, that were compiled with more or less regard for detail, there are over thirty other children who are said to be subjects of the same epidemic. Also several more children have been reported stricken in this vicinity in 1902 of the same disease. In reviewing the number of children, it is found that most of them are under three years, the youngest only a few months, and the eldest 10½ (excluding the Landry's paralysis). There is also one adult in the list. As to sex, a large proportion were males; 19 males and 6 females. There was marked similarity in the mode of onset, and this corresponds to recorded cases. Again the distribution of the paralysis: It was found in these cases much more frequent in the lower limb, the tibialis anticus muscle being particularly vulnerable. Another point about this epidemic: There was never more than one child in the same family affected, although in many of the cases there were other children in the homes. In one instance the second youngest was the only one paralyzed, out of a family of nine children, all under 12 years, and all within the same environment. Locality, soil, and sanitary conditions do not lend much light as to the cause of this disease. This point has been fully brought out by Caverly, in his report of the largest epidemic on record, in 1894; and by Newmark, in his "little epidemic," in 1898, in this state. The concensus of opinion is that acute anterior poliomyelitis is due to some infection; as yet there has been no conclusive evidence of a specific germ. If we consider again the fact that this infection, often without warning, strikes down the young and vigorous, and leaves them with more or less permanent injury, and, too, that medical treatment, thus far, has been of little use, are we not justified in looking forward to the science of preventive medicine as a means of escape from epidemics of this disease of childhood?

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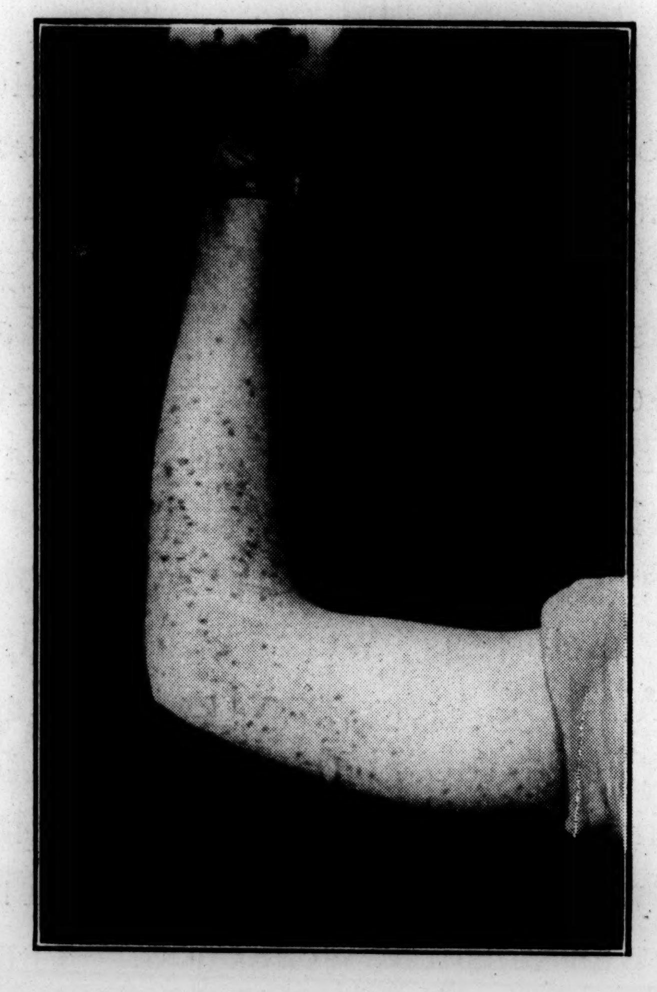
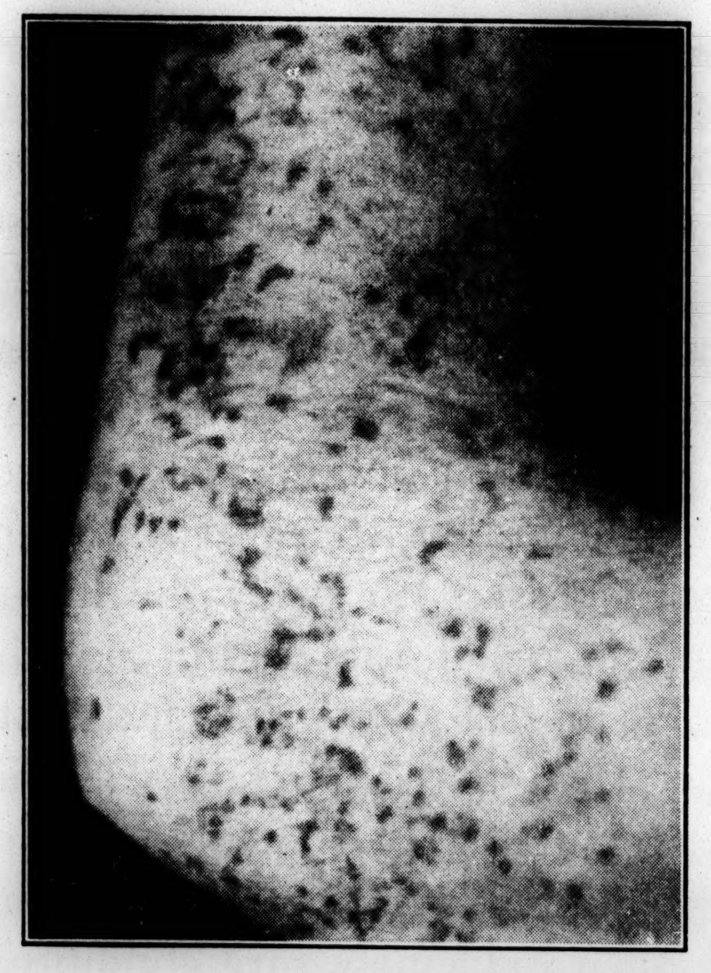
GONORRHEAL RHEUMATIC PURPURA.

By GEORGE L. EATON, M. D.

In reporting this rare condition, my intention is to show what variable conditions the gonococcus is capable of producing. Only a few years ago the gonococcus was considered to be localized only in the urethral mucous membrane, but since, authorities have found it in the cerebrospinal fluid, pericardium, endocardium, pleura, and synovial membranes. Doctor Hewes, of Boston, reports some interesting bacteriological experiments, undertaken in connection with gonorrheal rheumatism. He took blood from five individuals, all suffering from gonorrheal rheumatism, all having gonococci in their urethral discharge. From these specimens blood cultures were made, the acid-gelatin media of Turro being employed; in three negative results were obtained, but in the other two there were distinct colonies of bacteria, having the characteristics of the gonococcus, and were decolorized by Gram's stain. I cite these findings by Doctor Hewes, to show that the gonococcus is capable of being distributed to any part of the body by the blood under certain conditions and environments. Balzer, of Paris, reports a case of gonorrhea complicated shortly after its commencement by a very severe form of infectious purpura. Bacteriological examination demonstrated the presence of the gonococcus.



Lyton, under the head of secondary purpural affections, classifies all infectious diseases as an etiological factor. In presenting the complete history of this case, I wish to thank Dr. Donald R. Smith for the photographs here presented, showing the purpuric rash on the arms. Mr. A. N. F., age 19 years, presented himself for treatment on Oct. 27, 1902, and, in the course of the examination, he gave the following history: Mother and father alive and healthy, also three brothers, who are perfectly healthy. Patient never had any disease of childhood, nor consulted a physician until at the age of fifteen, when he contracted acute gonorrhea, which lasted for over a year before all signs had disappeared. He was apparently free from any urogenital disease for about fourteen months, when, unfortunately, he contracted another acute attack, which lasted six weeks. Within two months afterwards patient had contracted what seemed to be a third infection, the same lasting about one month. After the disappearance of this, the patient noticed that whenever dissipation was indulged in there would be a repetition of the above condition. The examination revealed the following: A slight mucopurulent discharge from the meatus, consisting of epithelium, pus cells, and a few gonococci, which decolorized by Gram's method. The urine was next passed in three glasses: First glass contained many tripperfaden, but clear; second glass, about the same as the first; third glass, cloudy, with many hooklets of Furbringer. Microscopic examination of centrifugated urine: First glass, pus cells, epithelium, and gonococci; third glass, pus cells, epithelium from seminal vesicles, also spermatozoa, all of which were dead. Prostate gland and seminal vesicles were next examined; the right vesicle was very much distended and exceedingly sensitive; so was the right prostate. There was expressed about two drams of secretion, and the following examination made: Pus cells in abundance, Boettcher's crystals, epithelium from seminal vesicles, a few testicular cells, and many spermatozoa, that were dead and deformed, showing that the condition was that of long standing. Many gonococci were also present, extra and intracellular. Urethroscopic examination showed an engorged mucous membrane, with here and there small areas of ulceration.



Treatment.—Massage of the seminal vesicles and prostate every five days, with urethral irrigation, including deep instillations of 1 per cent silver nitrate solution. Under the above treatment the patient improved nicely, discharge having ceased on or about November 10. On November 18 the patient complained of vague pains in different parts of the body. On November 20 rheumatic symptoms developed, localized principally in the ankles, shoulders, and left wrist. On November 21 the pain abandoned the above parts, and localized itself in the left knee, which became very much enlarged and painful, temperature reaching 102,° the rheumatic conditions being treated only locally, by fomentations and the like. On the morning of November 22 my attention was called to a peculiar rash extending from each knee to the ankles, and from the shoulders to the wrists, no other part of the body being affected. The photographs give a good idea of the purpuric condition. The treatment instituted for the rheumatism and purpura was ferruginous, with mild laxatives, the purpura disappearing in about two weeks, leaving the rheumatic condition, which gradually subsided in the course of three weeks. Patient was discharged on December 18, with the following final examination: Prostate gland and seminal vesicles normal; secretion from same showed the following: Very few pus cells, no gonococci (culture having been made for same), spermatozoa in a healthy condition. Since his discharge patient has indulged in alcoholic drinks and intercourse without the slightest inconvenience, nor has there been any sign of his old trouble.

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THE OCULAR MANIFESTATIONS OF SYPHILIS.

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Read before the Sacramento Society for Medical Improvement.

Syphilitic infection is so profound and general in its nature that scarcely any tissues of the body are free from its ravages. There is no other disease which affects so many organs and tissues as are attacked by syphilis. No age, class, or condition of men are free from its devastating influence. The innocent are only too commonly the greatest sufferers. It is transmitted to only one generation as syphilis, but the degenerated tissues and lowered physical organization is undoubtedly a hereditary legacy of several generations.

It is not surprising that the eye, being so delicate and highly organized a structure, suffers profoundly from a disease which at times reaches and disorganizes almost every bodily tissue. A very large percentage of every oculist's clinical work consists in the treatment of the varied forms of syphilitic manifestations that appear in the eye.

The initial lesion is occasionally seen on the lids or conjunctiva. Its characteristics are similar to chancres appearing in other localities. If one keeps in mind the possibility of the occurrence of a chancre in any part of the body, it is not likely to be mistaken for any other disease. The lids are occasionally the seat of ulcerations due to secondary or tertiary stages of the disease. The ulcerations are not always characteristic. It is therefore often necessary to study the history of the case, or, if this is not possible, it may be best to give specific treatment rather than to risk greater destruction of the function of the lids.

Syphilitic ulceration of the conjunctiva is an extremely rare condition, but when it does occur it is generally the result of the breaking down of a gummata. Syphilitic ozena or specific disease of the bony part of the nasal duct may be the cause of blenorrhea of the lachrymal sac, and syphilis is sometimes the cause of disease of the lachrymal gland.

Ophthalmoplegia, or paralysis of the ocular muscles, is commonly caused by syphilis. Alexander states that about 60 per cent of these cases are due to specific infection. Muscular paralysis is generally a late manifestation of the disease, rarely occurring before the eighth month. The lesion causing the paralysis may be located at any point in the course of the nerve, or it may be central, affecting the nuclei, the brain tissue immediately surrounding the nuclei, the third ventricle, the aqueduct of Sylvius, or the fourth ventricle. A few cases have been reported as the result of inherited syphilis.

It is not always possible to get a clear history in cases of muscular paralysis, and it will be necessary to exclude the common causes of the condition before determining the treatment needed. Among the other causes may be mentioned tuberculosis, tabes, diabetes, toxic affections, disseminate sclerosis, hysteria, brain tumors, traumatism, and rheumatism.

If syphilis is found to be the cause, or if it seems to be the most likely cause, large doses of iodide of potash will be indicated. If it is an early manifestation, or if mercury has not been administered in sufficient quantities, then it should be given for a time, at least, or in many cases the mixed treatment will be most advantageous. The condition of the patient may be such that other medication will be required. Galvanism will also be proper after the specific remedies have had time to produce their effect. The result of treatment is usually favorable, if the case is seen at an early stage.

Corneal disease due to syphilis is rarely the result of acquired disease, but is quite common as the result of inherited taint. Parenchymatous or interstitial keratitis is a condition with which one will usually find some of the stigmata of inherited syphilis. Inspection will generally reveal one or many of the following abnormal conditions: Prominent frontal eminence, a low or sunken nasal bridge, ozena or blenorrhea of the lachrymal sac. The second set of upper incisor teeth are often wedge-shaped, with semilunar indentation at their ends. At the angles of the mouth linear cicatrices are often present. The lymphatic glands of the neck will frequently be found enlarged, hard, painless, and with no tendency to suppuration. Periosteal swellings of the long bones may be found. Ear disease is also frequently an accompaniment of the corneal disease.

The diagnosis of interstitial keratitis is usually comparatively easy, and if some of stigmata above mentioned are present the decision is made more simple. The disease begins by the appearance of small, dim gray maculae in the deep layers of the substance of the cornea, generally towards its center; the corneal surface is dull and lusterless. The maculae gradually increase, and become confluent. A little later the cornea takes on the appearance of ground glass. Still later, vessels appear at the corneal border and extend towards the center. This again changes the character of the cornea, as the vessels give the membrane the appearance of pannus. The initial maculae begin at the border of the cornea less frequently than at the center, but they gradually increase, merge, and spread towards the center of the membrane, till it takes on a general cloudy or smoky appearance. As the vessels become developed, the cornea takes on a dull grayish-red hue.

When the heighth of the disease is attained, the iris can scarcely be recognized through the opaque cornea. The vision at this stage is usually reduced to the dim perception of outlines of large objects, or, more frequently, to the perception of light. The course of this trouble is always chronic. The prognosis must therefore be guarded. Clearing of the cornea can rarely be expected in less than three months, and often twelve months are required. Not infrequently permanent visual defect results. When the disease appears in one eye, we can pretty safely predict that it will appear in the other.

The treatment is both local and constitutional. The local treatment consists in the regular use of atropin and hot fomentations in the early stages of the disease. Atropin is particularly essential, as the iris is generally more or less involved in the inflammation. If the pupil is not kept well dilated, the future usefulness of the eye may be destroyed. Hot fomentations assist in allaying the pain and irritability of the eye. In the late stages of the trouble, when the inflammatory symptoms have disappeared, yellow oxide of mercury ointment will assist in clearing the corneal haze.

The constitutional treatment should be directed to the hereditary taint. It is well to begin with a course of mercury, and when the patient has come under its influence to supplant it with iodide of potash. Besides the mercury and iodides, other remedies may be needed to build the patient up. The eyes should be protected from bright light by colored glasses.

Syphilis has been estimated by various authors to be the cause of from 30 to 60 per cent of all cases of iritis. It has also been estimated that one in 200 to one in 20 syphilitic patients suffer at some time from iritis.

Syphilitic iritis commonly appears during the secondary stage of the disease, soon after the first eruption upon the skin, that is, within the first year of infection. However, iritis of syphilitic origin may occur in the late stages of the disease, and also in the inherited form. The common symptoms of iritis are severe pain, which is worse at night, defective vision, pericorneal injection, lachrymation, but no catarrhal secretion, iris sluggish and discolored, and pupil reacts slightly to mydriatics, conjunctiva injected and occasionally chemotic, more or less tenderness on pressure, and a tendency to posterior synechia. Some of these symptoms are often absent. The fact that pain is not present not infrequently is misleading, for the reason that it is usually so prominent a symptom of inflammation of the iris. A few drops of some mydriatic will generally clear up the diagnosis. Unless one is sure that it is not glaucoma, he should use no stronger mydriatic than cocain for diagnostic purposes.

In the secondary stages of syphilis the iritic inflammation often assumes a nodular form, the raised places on the iris resembling the papules on the skin of this stage of syphilis. In the late stages of syphilis the iris may also have a nodular appearance, but these enlargements are of the nature of gummata, and occasionally grow to great size, even causing destruction of the eye. It is quite common for both eyes to be attacked simultaneously, or one to precede the other only a short time. The onset is usually acute, but subacute and also chronic cases are seen. Syphilitic iritis of children is usually the result of hereditary disease, and is commonly serous, instead of plastic, in its nature.

Although many cases of syphilitic iritis are characteristic in their appearance, it is more frequent that one is unable from the iritic trouble alone to be positive of its nature. Other evidence must generally be sought for to clear up the diagnosis. If this is not to be found, one must arrive at the diagnosis from the history or by the process of excluding other possible causes.

The treatment of syphilitic iritis, like the other eye diseases that I have thus far discussed, is both local and constitutional. The local treatment consists principally in dilating the pupil to the full limit. This should be done promptly, for if adhesions form between the iris and lens, the eye is likely to be permanently impaired. To accomplish this important end, the atropin solution should be used vigorously the first few days, if necessary. One drop of a 1 per cent solution of atropin should be dropped into the eye every hour during the first two or three days, if less frequent use does not dilate the pupil. Care is necessary in the frequent use of so strong a solution, but with intelligent people, who will follow the instruction to turn the head so that the drops run out of the outer canthus, rather than into the nasal duct, serious trouble will be averted. The infrequent use of weak solutions too often entirely fails to dilate the pupil, and, as a result, the eye is left a permanently crippled member. Hot fomentations are also beneficial, and dionin has a calming effect upon the pain. It will frequently be necessary to give some internal remedy to enable the patient to get rest at night. The application of three or four leeches to the temple has a good influence when the inflammation is severe.

Syphilitic iritis in its severe form is usually accompanied with more or less inflammation of the ciliary body, and the trouble not infrequently implicates all the uveal tract,—the iris, the ciliary body, and the choroid. The ciliary body is not affected alone, except, perhaps, in rare cases of gummata that may appear in the late stages of the disease. When the disease attacks all the structures of the uveal tract, it is called uveitis, but from the external appearance only the iritis can be recognized. The inflammatory symptoms are more severe with more swelling of the lids and tenderness when the ciliary body is involved. The choroidal disease can only be recognized from the ophthalmoscopic appearance.

In the treatment of these inflammatory conditions, when due to syphilis, we must follow the well-known rules that govern the treatment of the same stage of syphilis when manifested in other parts of the body. As a very large majority of these cases are the result of secondary syphilis, it follows that mercury is the principal constitutional remedy. Valuable time is often lost by trying other remedies. The patient should be put under the constitutional influence of mercury as quickly as possible. Inunctions of mercury will, in my opinion, accomplish the desired result quicker than any other means of administering the remedy. When the patient has reached the point just short of salivation, some other less disagreeable form of mercury may take the place of the ointment. In case the manifestation in the eye is due to the late stage of the disease, the course of mercury can be followed by iodides with advantage. The iodide must be used in large doses to get the best result.

Syphilitic retinitis is another common complication of the secondary manifestations, and is also seen in the inherited trouble. It has been given different names, according to the ophthalmoscopic appearance. Choroido-retinitis is the form of inflammation in which both the retina and the choroid are involved in the diseased process. Simple syphilitic retinitis is characterized by a gray opacity of the retinal tissues surrounding the nerve entrance, the opacity following the vessels outward; the papilla is cloudy and indistinct. Retinitis with exudations is a form in which the vitreous becomes more or less cloudy with floating opacities. Retinal hemorrhages are occasionally seen in syphilitic retinitis, but with less frequency than in other retinal inflammations. The subjective symptoms are: Diminution of central vision, dancing spots, distortion of objects, dull vision at night, and other less marked symptoms, but the diagnosis must be made from the ophthalmoscopic appearance. The dangers of permanent blindness from syphilitic retinitis are very great, and treatment should therefore be prompt and vigorous. The treatment is principally constitutional, and consists in getting the patient under the specific appropriate to the stage of the disease that causes the retinal inflammation.

Retinitis may result from inherited or acquired syphilis. When it is caused by the acquired disease, it makes its appearance any time from six months to two years after infection. It is often chronic, and has a great tendency to recur. Notwithstanding proper treatment, it not infrequently leaves the eyes partially or completely blind. It often complicates syphilitic disease of the uveal tract.

Optic neuritis is generally a local expression of some general trouble. One of the frequent causes is syphilis, and it may appear as the result of the secondary or the late stage of the disease, and also as a result of hereditary taint. The nerve itself may be attacked by syphilitic disease, or the neuritis may be caused by syphilitic growth or disease along the course of the nerve or in the cranial cavity. The disease can be recognized only from the ophthalmoscopic appearance. The disc will be seen red and swollen, the borders of the disc are covered with the inflammatory exudate, and the vessels are more or less obscured by the swollen tissue.

The treatment of this condition is entirely constitutional, and its character must be determined by the stage of the disease that produces the local trouble.

A paper embracing so many diseased conditions can not treat exhaustively of the pathology and symptomatology of the various eye troubles. All that I have attempted to do is to point out the prominent symptoms, which may enable the general practitioner to arrive at a conclusion more readily as to whether the eye disease is due to constitutional trouble, and to emphasize the importance of general treatment in connection with the necessary local measures.

It is not an infrequent experience of mine to find patients depending upon iodide of potash to counteract the secondary manifestations of syphilis. Mercury is as essential for the cure of most ocular manifestations of syphilis as any medicine in the treatment of disease. Even in most of the late manifestations and in the hereditary trouble, a course of mercury previous to the administration of the iodide will greatly facilitate the progress of the case.

1005 K Street.

SOME INTERESTING CASES OF INSOMNIA.

By Francis Crosson, M. D., Albuquerque, New Mexico.

The following clinical reports were originally intended to have been incorporated in a paper on insomnia, printed in the "Occidental Medical Times" of October, 1902, but I decided that they would make that paper too lengthy. It was therefore deemed better to give them separate publication.

Case 1. Mrs. M. B., German housewife, aged 32 years, married 10 years, never pregnant. Seven years ago she developed a double pyosalpinx, as a result of gonorrheal infection, contracted from her husband, a black-smith, and a man of low order of intelligence. The altitude of Santa Fe, 7,000 feet, seemed to aggravate her disease very much, so that her physician at that time advised a change to the sea level as a probable measure of relief. She went to Philadelphia, Pa., and while there consulted, on the advice of friends, a good surgeon, who, after careful investigation of her condition, advised the removal of the tubes and ovaries and other diseased structures. This was readily consented to, but the patient requested that enough ovarian tissue be spared to prevent her from becoming absolutely sterile. This the surgeon promised her, and, when the operation was completed, and she had thoroughly recovered from it, he told her that she would menstruate regularly. This, however, she failed to do, much to the sorrow of herself and the disappointment of her husband, as they were both anxious to have offspring. Brooding over this condition, she had developed a very intense melancholia, when she consulted me about a year ago. Her most marked disturbance was a persistent and stubborn insomnia, which manifested itself shortly after her return to New Mexico. The insomnia was accompanied by mild delusions, entirely of a sexual character. Believing the condition to be purely psychic rather than pathologic, I began the use of hedonal in 15-grain doses, increasing this 5 grains per diem, until 30 grains were taken nightly. This was continued without intermission for 60 nights, during which period sound, refreshing, and healthful sleep was maintained. I then began reducing the dosage 5 grains per diem, until 10 grains were reached. This was adhered to for about 10 days, after which 10-grain doses were given biweekly. At the end of 6 months I was able to discontinue the use of hedonal entirely, and to-day the woman enjoys good health, is robust and strong. She has had no return of the menses, and seems now reconciled to her fate. She sleeps well, and is entirely free from hallucinations or melancholia. During the exhibition of hedonal in this case no unfavorable sequelæ were noted.

Case 2. Periodic dipsomania. H. G. B., male, American, aged 30; occupation, professional gambler. This patient consulted me to obtain relief from the liquor habit. He was well nourished and of strong physique, all the vital organs in sound condition, with the exception of the stomach, which labored with a gastritis, due to irritation from too copious libations of whisky, which was the only form of drink he used on his "bats." When he came to me, I detected the near approach of alcoholic delirium, and so advised him. He promised to be good and do what I suggested. I allowed him one last "parting smile," and then shut off his liquor, substituting therefor, when the craving approached, hot clam juice, with plenty of red chili (pepper) in it. The first night I gave him 40 grains of hedonal, in divided doses of 10 grains each, at intervals of 30 minutes, until sleep was produced. I kept him on a stimulating liquid diet, with rest in bed and 30-grain doses of hedonal for 4 days, after which, the stomach having recovered its normal condition, solid food was allowed, and 30-grain doses of hedonal ordered for the next 15 days. At the expiration of this time the dose of hedonal was reduced to 15 grains, and this maintained for 2 weeks longer, when all treatment was abandoned. The patient is perfectly well to-day, sionally seen in syphilitic retinitis, but with less frequency than in other retinal inflammations. The subjective symptoms are: Diminution of central vision, dancing spots, distortion of objects, dull vision at night, and other less marked symptoms, but the diagnosis must be made from the ophthalmoscopic appearance. The dangers of permanent blindness from syphilitic retinitis are very great, and treatment should therefore be prompt and vigorous. The treatment is principally constitutional, and consists in getting the patient under the specific appropriate to the stage of the disease that causes the retinal inflammation.

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Case 3. Mrs. H. S. C., aged 35 years, 4 children. Periodical dipsomania, with drug addiction. This patient consulted me a few weeks ago for relief from insomnia. She had recently a severe attack of follicular tonsillitis, during the course of which she was obliged to care for a sick child and a husband suffering from a surgical injury. Loss of sleep for several nights, caused by the unusual demands of her family, brought on a "drink storm," which lasted several days. Her physician gave her large doses of trional, which completely failed to produce sleep. When seen by me, the heart was depressed to such an extent that I was alarmed. She resided at an altitude of 7,000 feet, and I at once had her brought here, where the altitude is 5,000 feet. I used stimulants cautiously, and began stimulating liquid nourishment, given at intervals of two hours. This, with rest and the exhibition of hedonal, brought her over the rough places in one week. At the close of the second week she had so far recovered that she was allowed to visit her friends, where she remained another week, at the end of which time she was able to return home. In this case I was obliged to use large doses of hedonal to secure any sleep at all. The first night 60 grains were given, in divided doses of 15 grains; the second night, 50 grains; third night, 40 grains; fifth night, 30 grains. This latter quantity was continued for 8 days, when the dose was again cut to 20 grains. She now takes 15 grains every second night, and sleeps nicely. During the exhibition of hedonal in this case, no bad effects of any kind were observed.

Case 4. Mrs. M. G., aged 26 years, married, one child. Tuberculosis of the lungs, third stage. The patient, six months ago, before coming to New Mexico, was treated at Omaha, Neb., by the X-rays, which entirely failed, after which she took a "copper cure," with the same results. I was called to treat an extensive slough under the right scapula, which resulted from the X-ray. Incidentally I discovered that this patient was taking enormous doses of heroin. She complained of insomnia, and I at once withdrew the "copper cure," and cut down the heroin to the physiological dose. Hedonal, 30 grains, divided doses, was employed for several weeks, securing refreshing sleep, with no perceptible by-effects.

In conclusion, I will state that I have employed hedonal for the past eighteen months. In all my tuberculous cases, which are numerous, I depend upon it entirely to secure sleep. In nearly all of these cases, especially those in the third stage, insomnia is present, and our practice of giving such patients opium in some form has, I am sure, shortened their lives. I am pleased, therefore, to be able to record my experience, and to urge upon physicians who treat the various diseases attended by insomnia that in hedonal they have a most useful agent to secure calm, restful, and invigorating sleep, and an agent likewise devoid of any danger whatever, so far as my observations have gone.

DEPARTMENTS

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. Hoisholt, M. D.

Chloretone as a Hypnotic in Insanity.—Dr. Cappelletti, after describing the chemical and physical properties of chloretone, says that he has found it useful in cases of insanity as a hypnotic, in doses of 1 to 2 grms. (15 to 30 grs.), and that he has not observed any unpleasant after effects. (Riforma Medica-Allg. Jeitschi fur Psychiatric, Nov. 20, 1902). This report of Dr. Cappelletti does not corroborate the experience of Dr. Wm. Rush Dunton, at the Sheppard Hospital. In 11 out of 20 cases in which Dr. Dunton administered chloretone, it had no effect, or the effect was so slight that he had to resort to the use of other hypnotics. In the other 9 cases, symptoms of a severe nature set in, the patient became prostrated, and albuminose was found in the urine, which Dr. Dunton ascribed to an unfavorable influence upon the heart.

A Case of Multiple Personality.—Dr. J. Allen Gilbert, of Portland, Ore., reports the case of a patient who was admitted to the hospital, following a head injury. He was discharged and readmitted several times, on account of peculiar actions. There seemed to be loss of memory, and he was hynotized, in order to ascertain if his memory could be assisted. When he awoke, it was found that he had changed his personality, and subsequent sittings developed that there were three personalities. An almost complete history of his life was obtained by joining the accounts given by the three personalities, the hiatuses probably representing transitional or mixed states. Usually his changes of personality took place while on a train or immediately afterwards. Finally an attempt was made to unite the events of his different lives into a unitary consciousness while the patient was in a hypnotic state. This proved quite successful. The author terms the process a psycho-epileptic exchange of personality.—Medical Record, Aug. 9, 1902.

The Projection of the Retina upon the Cerebral Cortex.—Prof. Henschen, of Upsala, Sweden, read a very interesting paper upon this subject before the last Scandinavian Congress for Internal Medicine, at Helsingfors, Finland. After speaking of the difference in opinion as to the exact location of the visual center, in spite of all the work which has been done by anatomists and physiologists in this direction, which is due to the difficulty in proving the results of lesions produced in the small brains of the animal experimented upon, Henschen expresses the hope that the question may finally be solved by anatomical examination of carefully-observed clinical cases. He then goes over the latest information on the subject. The optic tracts may in general, he says, be considered to consist of two neurons, the first one extending from the retina to corpus geniculatum, the second extending from this to the cerebral cortex. The nerve-fibers pass from the retina through the nervi optici, and undergo a partial decussation at the chiasm. By reason of this decussation, a homonymous hemianopsia results whenever a lesion affects the optic tract back of the chiasm. The nerve-fibers of the optic nerves terminate principally in corpus geniculatum, and are brought into contact through intermediate ganglion-cells with the nerve-fibers, which form a narrow bundle (Gratiolet's), extending from corpus geniculatum to the cortical surface of the occipital lobe. The chief difference of opinion concerns the question as to whether the visual center is limited to the occipital lobe, or whether it also embraces the gyrus angularis, and whether it is located on the lateral as well as on the median portion of lobus occipitalis, or confined to the latter part. Monakow, who has made extensive examinations, thinks it is located in the lateral part of the occipital lobe, and extends into the gyrus angularis. Against this idea of Monakow, it may be said that, in the cases where hemianopsia developed, following lesions of the lateral portion of the lobe, the lesion would always be found to extend into the depth, so as to injure the fibers which terminate in the median side of the occipital lobe. In other cases there was no disturbance of vision, although the cortex of the lateral surface of the lobe had undergone an extensive lesion. On the other hand, the hemianopsia was constant where there was a lesion of the median surface, and this lesion affected the part of the cortex which surrounds the fissura calcarina. In this connection, Professor Henschen spoke of a case which he had examined and published, in which the lesion was confined to the fissura calcarina, and in which hemianopsia had developed. Henschen was therefore forced to believe that the visual center is located here. One would be inclined to assume that the cerebral cortex at the location of the visual center would show a structure differing from that of other parts of the cortex. Already, in 1892, the writer of the paper had demonstrated the existence of large, characteristic cells in the cerebral cortex at this place, cells which had been more accurately described by others (Ramony, Cahol). Flechsig has expressed himself as being in sympathy with this understanding of the specific structure of the visual center in his report of researches as to the myelinization of the nerve-fibers. Professor Henschen then took up the question whether one would be able to make a further localization within the visual center, or, in other words, Can the retina be projected upon the cerebral cortex? It is a question which is also of practical importance to the understanding of the psychical activity of the brain, and the principle of the projection is in reality assumed in the generally-accepted opinion that the right hemisphere corresponds with the right half of the retina, and vice versa. Doubt has, however, been expressed as to the existence of an upper and a lower half in this projection. One knows that the fibers in the nervi optici are so arranged that those which come from the lower half of the retina are the most inferior, and that they, arranged in fascicles, enter the corpus geniculatum in about the same manner. Professor Henschen could, however, now report that he had recently observed a case which showed that, in a lesion of the upper half of the corpus geniculatum, blindness resulted in the upper half of the retina, and he furthermore showed pictures from still another case, in which there was a hemianopsia of the lower quadrant and lesion of the dorsal portion of the corpus geniculatum. In the last-nite proof of the existence of a projection upwards and downwards in the corpus geniculatum. In the last-mentioned case, Professor Henschen had traced the normal nerve-fibers to the most inferior convolution of fissura calcarina, and he had found that the upper convolution of this fissure corresponded to the upper half of the retina, and the lower convolution of fissura calcarina to the lower half of the retina. Several other cases corroborated this finding, and the writer stated that there is nothing found in the literature which contradicts it; on the contrary, it has been shown that a lesion of a limited portion of the cortex may cause a scotoma, and Henschen was able to show illustrations from two such cases, in one of which the diagnosis was made intra vitam. The most difficult question remaining is the one concerning the localization of macula lutea. It is a well-known fact that the macula lutea always remains intact in hemianopsias and one has therefore resorted to the theory of a bilateral innervation of the macula lutea. However, the macular field has even sometimes been found intact where there was a bilateral lesion. The best known of these cases is the frequently-cited one of Forster, which was anatomically examined by Sachs. In this case a total hemianopsia of both retinal halves was found, but with preservation of central vision; extensive lesions were present in both occipital lobes. Forster thought that the reason for the preservation of the macular field was that its central portion was especially well nourished, and, as this likewise was true of the point of the occipital lobe, which in this case showed no lesion, he referred the localization of the macula lutea to this part of the cortex. If one, however, examines the case more minutely, one will find that Forster's interpretation is not correct. His illustrations show, namely, that the lesion has penetrated to such a depth as to interrupt all connection between the point of the lobe and the corpus geniculatum. On the other hand, it may be seen that the only part of the cortex from which the connection by fiber is not interrupted is the anterior part of the fissura calcarina, and here we must place the localization of macula lutea. And still the literature contains at least one case which contradicts this view. The form of the macular field is constant, which upsets the theory of v. Monakow that macular fields are found scattered in the cerebral cortex. All the investigations made in recent years have only served to support the theory, expressed by Professor Henschen in the early part of 1890, that the center of vision has a definite localization in the fissura calcarina, that the upper convolution of this answers to the upper half of the retina, the lower convolution to the lower half, and that the retina is found projected upon the part of the cerebral cortex around the fissura calcarina. The experimental results reported by Henschen were at decided variance with the theory of v. Monakow concerning the center of vision and its organization.—Hospitalstidende, Aug. 6, 1902.

Confinement to Bed in the Treatment of the Insane.—Dr. Pelas advises to put to bed all cases of acute or recent psychoses; the restlessness subsides almost always when cases are thus treated. He is, however, opposed to this course in chronic cases. If the restlessness is very great, or if confinement in bed is only made possible by extreme compulsion, he rejects this treatment also in acute cases, in which cases it may then even have an outright injurious effect.—Annal. Med-psych. Allg. Zeitscher f. Psych., Nov. 20, 1902.

The Frequency of Inequality of the Pupils and Its Diagnostic Importance.—Professor Schauman, of Helsinfors, Finland, read a paper on this subject at the last Scandinavian Congress for Internal Medicine, in which he said that of recent years authorities have come to look upon inequality of the pupils as a symptom of less diagnostic importance than was formerly thought, and that one is now more inclined to attach pathological importance to it only when it is combined with a diminished or absent reaction to light. The writers who have investigated the subject have been able to show the presence of an inequality of the pupils in healthy individuals in 1-10 per cent, while in different internal diseases it was present in 18-46 per cent. Professor Schauman had confined his investigation to its presence in disease, and had found the symptoms sometimes constant, sometimes transitory. The reaction to light was usually intact. being absent in but four cases, in which there in all probability was an organic disease of the nerve. Among 1,186 polyclinic patients he found the inequality in 331, or 27.9 per cent; among 723 clinical cases he had observed it in 273, or 37.8 per cent. The inequality was found equally frequent in men and women; the left pupil was found more frequently enlarged than the right (this corroborates what has been found by other writers). In 4 per cent of the clinical cases Schauman found "an alternating mydriasis," i. e., sometimes the one, sometimes the other, pupil was found the larger. This symptom was in former years considered a signum mali ominis; but the writer agrees with Koenig in considering the symptom of no importance, provided there is a reaction to light, and provided that there is otherwise no symptom of cerebral or spinal disease. Inequality of the pupils is much more frequently met with in neuroses than in other diseases, and the writer is of the opinion that when the phenomenon can not be directly ascribed to disease of the nervous system or of other organs of the body, it is evidence of a constitutional anomaly, an asthenic diathesis.—Hospitalstidende, Sept. 24, 1902.

Active Movements in the Chronic Stage of Paralysis.—Dr. E. H. Arnold describes a form of apparatus for keeping up the volitional control of the muscles in cases in which the motor centers are impaired from hemorrhages, or in cases of cerebral or spinal paralyses of an inflammatory character. The treatment is begun as soon as all danger of a recurrence of the cause has passed. The apparatus consists of a broad board, upon which the patient lies, and which has two, arc-shaped boards attached to each side, one corresponding to the lateral movements of the foot, the other to the lateral movements of the hand. To do away with the resistance between the moist limb and the board, the limb is attached to a car made of a small board on castors. As the patient's power increases, the resistance is increased by attaching a weight by means of a cord and pulley. —New York Medical Journal, vol. 76, p. 277.

MATERIA MEDICA: THERAPEUTICS.

By Z. Taylor Malaby, M. D., San Francisco.

The Treatment of Pneumonia.—Sir D. Duckworth ("British Medical Journal," November 15) says the treatment of pneumonia is strictly the treatment of the patient suffering from it. It is a simple disease in children; it is not a dangerous disease in the young or in those who have been previously healthy; it is more dangerous to those who have reached forty years of age; it is extremely dangerous in the old; and absolutely fatal in the drunkard. A warm bed and careful nursing are essential parts of the treatment. The appetite is lost, and there is no object in forcing food; the patients usually do well on a fever diet, milk and beef tea. A temperature of 102° or 103° Fahr. appears to be a necessary part of the disease, and no steps should be taken to check it, so long as it keeps within limits. But anything over 105° Fahr. may be called hyperpyrexia, and demands attention. Sponging with ice-water, the use of a cradle under the bedclothes to which buckets of ice are suspended, or ice-bags, are usually effectual. The best drug to use is quinin, in five-grain doses every two or three hours. A simple fever mixture of potassium citrate and ammonium acetate is often of service. Delirium is usually seen in elderly alcoholic patients, whose cases often prove fatal. Insomnia, especially if it occurs toward the crisis, is a very grave matter. The author advises the use of morphin in small doses in those cases in which there is no involvement of the kidneys. Failure of heart power is a serious thing, and manifests itself either by cyanosis or by irregularity and weakness of the pulse. For the former nothing is better than moderate blood-letting; for the latter, strychnin given hypodermically, or musk, which is of the greatest value in pneumonia. As regards alcohol, some patients do not require it. In the majority of cases, from two to four ounces of brandy are sufficient in the course of each day. In winter-time hot poultices may be applied to the affected side; in summer, cotton-wool sprinkled with spirits of camphor. Dry pleurisy is a constant accompaniment or part of pneumonia, and the pain of it may be relieved by the application of two or three leeches.—New York Medical Journal.

The Prevention of Seasickness by Means of Orexin Tannate.—(C. V. Wild, Archiv F. Schiffs.—und Tropen.—Hygiene, vol. 6, p. 24; Die Heilkunde, 1902, p. 165).—The author administers orexin tannate for the prevention of seasickness, as follows: 0.5 g. (gr. viii) are taken in 250 c. c. fluid (such as milk, tea, bouillon) three hours before the ship sails, and two hours later a plentiful meal to be taken. His observations have brought him to the following conclusions: (1) That people usually subject to seasickness are free from illness, at least for several days, if the drug is taken in exactly the manner described above; (2) that the illness is not prevented where the drug is taken in any other manner; (3) that in one case, while the drug prevented illness on the day of sailing, seasickness set in on the following day. He ascribes this ill result to the fact that in this case the meal taken two hours after the administration of the orexin tannate was insufficient.—Medical Review.

Prophylaxis of Diphtheria by Pre-

ventive Injections of Antitoxin.—Sevestre (Rev. Mens. des Mal. de l' Enf.) concludes: (1) That preventive injections are of value in immunizing children exposed to the danger of diphtheria. They are never followed by bad results, and produce, at most, ephemeral skin eruptions; more rarely, joint pains. Unfortunately, the period of immunization is short, not exceeding three or four weeks. (2) Injections are indicated in families where one member has contracted diphtheria, and in institutions where many children are congregated, where diphtheria has broken out. (3) Even in the absence of distinct cases of diphtheria in institutions, injections may be of value, for instance, in scarlet fever pavilions, etc. (4) The giving of injections does not imply the dispensing with other prophylactic measures (disinfection and isolation), but renders these easier and more efficacious.

For Eczema.—Dr. Fox recommends a lotion of ten parts of chrysarobin and of salicylic acid in fifteen parts of ether and enough flexible collodin to make a hundred parts. This is painted over the "mother-of-pearl" patches every day or two, until the scales vanish and only smooth white spots remain.—Ex.

Ergot in Hemorrhages of Other than Uterine Origin.—Wm. B. Fenn concludes: (1) In profuse hemorrhage from the lungs, appearing in mouthfuls, the likelihood exists that an artery of considerable size is ruptured or eroded, and our object should be to quiet the circulation and lower the blood-pressure. We should use rest, and such drugs as aconite. Under such circumstances ergot should never be given. (2) In slow oozing the source of the bleeding is usually the congested capillaries in the mucous membrane. Ergot may stop the bleeding by constricting these capillaries; but, as such hemorrhage is usually decidedly beneficial, and stops when the congestion is relieved, and as ergot is not well borne by the stomach, and is decidedly disagreeable to take, the use is also here rather contraindicated than otherwise. Digitalis, which also contracts the capillaries, would be quite as useful. It is said that Trudeau, at Saranac Lake, uses the drug for this purpose. (3) Uterine hemorrhage seems to furnish the preeminent, and, perhaps, the only indication of ergot as an internal styptic.—American Medicine.

Methylene Blue.—Drs. J. T. Morrow and W. D. Allison, in the "Medical News" for Dec. 6, 1902, coincide with Thayer as to the relative value of the methylene blue and quinin in malaria. They conclude that the methylene blue will destroy malarial parasites in many cases, but is less certain than quinin. It is probably most valuable in chronic cases, but has no advantage over quinin, while its effects are ordinarily more unpleasant than those of quinin. It is useful in cases that can not take quinin. Its use in cases of pregnancy is undetermined. It is probably valuable in treatment of hematuric and hemoglobinuric fevers, on account of its diuretic action, though this is yet to be determined. They believe that quinin is quicker and much more certain, and would rely upon it rather than upon methylene blue.

Antistreptococcus Serum in Scarlet Fever.—Adolf Baginsky reports comparative observations with the original serum of Aronson. Sixty-two cases were inoculated, of which seven died, a mortality of 11.3 per cent. Sixty-three cases, occurring in the same epidemic, were treated in the ordinary manner. Of these, nine died, a mortality of 14.3 per cent. A detailed study of the inoculated cases shows that in none was the course of the disease shortened or the symptoms favorably influenced; indeed, in most the course was lengthened, and marked by the development of serious complications, such as nephritis, suppurative adenitis, and joint symptoms. In most of the cases, 20 c. c. of the serum was given in one inoculation, and not repeated. In a few, however, this dose was markedly increased, and in four six injections of 20 c. c. were given. Such an increase in the dosage did not in any way improve the results or lessen the complications. Recently Aronson produced a new serum, which Baginsky has tried with somewhat better results, in that fewer complications have followed its use. It can not be said, however, that it had any marked influence on the course of the disease, as ordinarily observed. These results are in striking contradiction to those recently reported by Moser and Paltauf. This may be due to the difference in the serum used by the latter observers, which was obtained from streptococci which had not been submitted to animal passage, as is the procedure followed by Aronson.—Berliner klinische Wochenschrift.

Nutrient Enemata.—1. Beef tea, three ounces; yolk of one egg; brandy, one-half ounce; liquor pancreaticus, two drams. 2. One whole raw egg; table salt, 15 grains; peptonized milk, three ounces; brandy, one-half ounce. 3. Beef tea, two ounces; brandy, one-half ounce; cream, one-half ounce. 4. Beef tea, two ounces; one whole raw egg. 5. Beef juice, one ounce. 6. Beef essence, six ounces. 7. Whites of two raw eggs; peptonized milk, two ounces; two eggs.—Medical Critic.

The Treatment of Scarlatina.—J. A. Le Sage declared that the treatment of scarlatina to-day is considered, to a great extent, under hygiene and the surroundings of the patient. Every patient with scarlatina should be submitted to a rigorous isolation, especially at the time of subdesquamation of the skin, for these tiny particles can spread the disease far and near. The physicians and attendants ought always to put on linen garments before entering the sick-room, and take them off on coming away from the patient. They should also plunge the hands into an antiseptic solution after each visit. These garments are put into boiling water. After the patient recovers, the chamber should be carefully disinfected. The room should be large and well ventilated, and the patient confined there as long as the desquamation lasts (thirty to forty days). The throat and nose should receive special attention. As to food, the milk regime, absolutely adhered to, is best in infectious maladies, not only to reduce to a minimum intestinal or gastric fermentations, but to assure diuresis, which is so necessary in these cases. Cold drinks should be given in abundance, such as lemonade, etc. Salol, benzonaphthol, benzoate of soda, and calomel are excellent when indicated. If the eruption is slow in appearing, a lukewarm mustard bath will facilitate it. During desquamation, soapy baths, followed by antiseptic unctions, will hasten the process. The eyes and ears should be bathed with boric solution.—L'Union Medicale du Canada, January, 1903.

Pyrosis :—

℞: Bismuthi subcarbonatis	ʒ iv.
Tinc. hyoscyami	fl. ʒ iv.
Aq. camphorae	q. s. ad fl. ʒ iij.

M. Sig.: Shake. Teaspoonful an hour before meals.

Indications.—Used in pyrosis with excessive secretion of hydrochloric acid.

℞: Argenti nitratis	gr. iv.
Ext. hyoscyami	
Pulv. Camphorae	aa gr. vj.

M. et ft. pilulae No. xxiv. Sig.: One pill an hour before meals.

Indications.—Used in pyrosis with excessive secretion of hydrochloric acid.

℞: Tinc. hyoscyami	fl. ʒ iv.
Liq. strontii bromide (Paraf Javal)	q. s. ad fl. ʒ viij.

M. Sig.: Two to four teaspoonfuls in full glass of water, with meals.

Indications.—Used in pyrosis with excessive secretion of hydrochloric acid.—Ex.

Dysmenorrhea :—

℞: Ext. conii alc	gr. xv.
Ext. scammonii alc	
Ext. opii	aa gr. b.

M. Ft. Pil. No. x. Sig.: One pill three times a day.—Gaillard's Medical Journal.

OBSTETRICS AND GYNECOLOGY.

By WALLACE A. BRIGGS, M. D., Sacramento, Cal., and
GEORGE B. SOMERS, M. D., San Francisco.

Ovariotomy Seven Years after Hysterectomy.—Bantock makes an interesting observation on a case where the ovaries were left purposely in a case of hysterectomy. Seven years later ovarian disease was diagnosed and a tumor weighing over five pounds was removed. There was no trace of the right ovary to be found. The case is reported as bearing on the theory that the ovary plays some part in the animal economy apart from ovulation and spares the patients, if left, of the inconvenience attached to the menopause. He holds that there is no evidence whatever to support this theory. Many thousands of women have suffered the loss of their ovaries and it ought to be possible by this time to produce some evidence of the injurious effects of such a loss. On the contrary, the perfect health which the majority of these women enjoy bears eloquent testimony to the fact that no injury, either mental or physical, has resulted. In the case reported, the patient suffered an unusual extent from flushings and other nervous disturbances after the first operation, even though the ovaries remained. He holds further that after the menopause, the ovaries are not only useless organs but are even dangerous, and are often the seat of disease, which requires serious operative interference. When tubes and uterus are removed it becomes a duty to remove the ovaries. —British Medical Journal, Jan. 17, 1903.

Conservative Operations on the Ovary.—In an article by L. H. Dunning, he states his belief that cystic degeneration of the ovary is a progressive disease in many cases, and makes the question of conservative work a difficult one of solution. He concludes as follows: (1) Operations on the ovaries that preserve the menstrual and reproductive functions should be employed, instead of complete extirpation, especially in cases of extirpation of one ovary, and where the remaining ovary shows, as pathological changes, a single cyst of moderate size, or several small cysts, or a single hematoma. (2) Healthy displaced ovaries may, with advantage, be anchored in as nearly a normal position as possible, by stitching them with fine catgut to the posterior surface of the broad ligament, or by shortening the infundibulo-pelvic ligament. (3) Cases of sterile married women and married women who are using means to avoid pregnancy are unfavorable subjects upon whom to do conservative operations upon the ovaries. (4) The writer believes that in pus cases, such conservative operations should, as a rule, be avoided.—American Gynecology, December, 1902.

Anterior Transplantation of the Round Ligaments for Displacements of the Uterus.—Ferugson describes the following method: (1) Median incision. (2) Stab wound through each rectus muscle, one inch from the edge of the incision. (3) Pass an artery forceps through the opening and seize the round ligament and a portion of the broad ligament beneath it near the uterus. (4) A continuous suture is inserted, running along the parietal peritoneum from the puncture downward to the side of the bladder, and back posteriorly to the round ligament near the uterus. When the suture is tied an anterior-posterior partition of folded peritoneum is thrown between the bladder and iliac regions on each side. (5) Drag the proximal end of the round ligament through the rectus with the forceps already attached to it, and sew it to the anterior sheath of the rectus, leaving a stump about half an inch long between the parietal peritoneum and the uterus.—New York Medical Journal, Jan. 17, 1903.

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THE PLAGUE AND POLITICS.

When the conference of State Boards of Health adjourned about six weeks ago, many of the members congratulated themselves that they at last cleared away several of the perplexities that had made California's plague situation so dangerous and so uncertain. It was supposed that, in the face of the evidence offered to substantiate a diagnosis, long proven, no man and no newspaper would ever dare to carp at, much less defiantly deny, the truth. It was hoped that harmony, or at least non-interference, would prevail, and that all would work for the one and single object sought,—the eradication of the pest. It was considerately believed that, when the California representative, Dr. Gardner, acknowledged the existence of the disease, the truth of the diagnosis, and pledged that the demands of the conference would be complied with fully and completely, he spoke with authority. Such, at least, was the interpretation of his assurances by those assembled.

It was naturally supposed, with the history of the past in mind, that the demands of the conference would stir up some animosity, but no such lament was expected from the press and people that they were persecuted, that they were discriminated against, and that such rulings were unfair, unjust, and for a condition that did not and never did exist. So vehement and so bitter were their protests that it seemed possible that the old policy would be insisted upon. On the return, however, of Dr. Gardner, who had witnessed the determination of the conference, a more conservative view gained ground, with the result that some show at least was deemed necessary to ward off more serious trouble. The pointed and vigorous words of Charles D. Smith still rang out ominously and threateningly to California:—

> "What I want to know is how far, and with what honesty of purpose, the state and local authorities in California are going to cooperate with this service; how soon the perversion of fact and the lukewarm efforts and this insistence that plague does not exist, on the part of those authorities there, is going to cease; in other words, how soon are they going to stop their obstructive tactics and get down and cooperate with General Wyman and his service? That is what I want to know, and that is what my board wants to know. If I mistake not the temper of this conference, that is what every one of us wants to know. I shall not be satisfied to go back and make a report until I can report something definite, one way or another, with reference to this matter. So far as we are concerned, we have a right to demand something more definite and more specific than anything that has been offered to us so far, and it seems to me the proper thing for this conference to do is to find out some way, if possible, to get that assurance; and until we get that assurance, I, for one, shall never be satisfied with the question as to what is to be done there."

The telegram of Dr. Wyman that "the resolutions passed by the conference but feebly express the very strong and determined feeling that prevailed;" "the acknowledgment of the existence of plague would not affect the transport service in San Francisco, nor the matter of quarantining the state, for the Bureau and the conference both know the disease is there as well as if the state admitted it, but, if acknowledgment is not made by California authorities, the work of elimination is necessarily embarrassed, and, when conference meets again, emphasis will be laid on this fact, and suspicion thrown on the work as undertaken, and may occasion the passing of the transport and train inspection resolutions, which were postponed;" upon such messages but one interpretation could be placed, and, though a stern and strenuous fight was made, giving some assurance superficially that all would be well, there were those who believed that the congress was a failure, and it was.

The objects for which the Boards of Health were brought together were to secure an acknowledgment of the existence of the disease and some means to prevent its spread, neither of which points were gained by any direct and specific work of that body. That the demands aided the results is true; but, had the work depended alone and entirely upon the requirements of this body, the story of the past would have been retold. Fortunately for the country, the epidemic of Mexico had so increased that many ports were closed against our ships; our commerce was threatened on all sides; our city was charged with having furnished the poison for the Mexican towns, because of her policy of concealment, her inefficiency and neglect in carrying out plans for protection and prevention, and finally our commercial interests realized that the craven dollar, the only thing that appeals to them, was slipping away. Therefore these conditions, this unrelenting spread of the disease, were the true causes that led up to a conference of commercial and political interests, and of which came the following agreement:—

[No. 1.]

"Whereas, The boards of health of other states and territories have become alarmed at the reports of bubonic plague in San Francisco during the past three years; and,

"Whereas, But 93 cases have been reported by all health authorities during a period of these 35 months, and that the last case reported was Dec. 11, 1902; and,

"Whereas, The health authorities of 21 states and territories, in a conference called for that purpose at Washington, January 19, declared that the presence of plague had 'been established beyond debate by the investigations of Kellogg, of the city board; by Pillsbury and Ryfkogel, of the state board; by J. Wite, M. White, Flint, Currie, Carmichael, Blue, and Glennan, of the Public Health and Marine Hospital Service; by Flexner, Barker, and Novy, a special commission acting under federal authority; by independent and disinterested investigators in Chicago, Boston, New York, Washington, Baltimore, Philadelphia, and Ann Arbor, working from material obtained in San Francisco; by a case of human plague in Ann Arbor due to an accident in the handling of a culture of plague bacillus obtained in California,' and said plague conference did attempt to declare a quarantine against California, to cause the transport service to be removed from San Francisco, and to place medical inspectors upon all the trains going out of the state, and but for the most strenuous efforts of Dr. Gardner, representative of the State Board of Health, could have succeeded in so doing; and,

"Whereas, Said conference did demand that the city and state health authorities act in harmony with the Public Health and Marine Hospital Service to carry out any sanitary regulations which that service may deem necessary, or quarantine would be established against California, at its next meeting, to be held in April: and,

"Whereas, The great interests of California, and especially those of San Francisco, demand that no neglect of our citizens should hinder the march of progress which has now been so happily begun; it is, therefore,

Resolved, That this mercantile joint committee, consisting of the officers and other representatives of the State Board of Trade, the San Francisco Board of Trade, the San Francisco Chamber of Commerce, the Merchants' Association of San Francisco, the Merchants' Exchange of San Francisco, the Manufacturers' and Producers' Association of California, and the California Promotion Committee, hereby strongly urges the governor of the State and the mayor and supervisors of San Francisco to take such steps at once as shall secure a prompt cooperation of the boards of health of the city and State, under the supervision of the Public Health and Marine Hospital Service, to the end that all danger from the bubonic plague may be eradicated; that all fears from infection may be removed; that the confidence of the boards of health of the other States and Territories may be restored, and that no injury, however remote, may result to the foreign and interstate commerce, and to this end we hereby pledge to the officials of the State and city every aid and support of the various commercial bodies which we represent; and we also ask that the governor of the State and the mayor of the city join in the signing of the following statement:

Whereas, competent medical authority has declared that bubonic pest has existed to a limited extent in the restricted area known as Chinatown in San Francisco, the last case having been reported Dec. 11, 1902, and although the health authorities have exercised sanitary supervision over this section in the past,

Nevertheless, this undersigned joint official statement is promulgated in accordance with the resolutions adopted at the conference of State health officers, held at Washington, D. C., Jan. 19, 1903, as an assurance that there is no present or future danger from that disease, inasmuch as complete and harmonious action by all the health authorities concerned is hereby assured and will be maintained.

Mercantile Joint Committee.
Frank J. Symmes,
Chairman.
L. M. King,
Secretary.

Representing California State Board of Trade, San Francisco Board of Trade, San Francisco Chamber of Commerce, Merchants' Association of San Francisco, Merchants' Exchange of San Francisco, Manufacturers' and Producers' Association of California, California Promotion Committee.

[No. 2.]

SUPPLEMENTARY OFFICIAL STATEMENT.

San Francisco, Cal., Feb. 2, 1903.

Whereas, competent medical authority has declared that bubonic pest has existed to a limited extent in the restricted area known as Chinatown in San Francisco, the last case having been reported Dec. 11, 1902, and, although the health authorities have exercised sanitary supervision over this section in the past, nevertheless this undersigned joint official statement is promulgated in accordance with the resolutions adopted at the conference of state health officers, held at Washington, D. C., Jan. 19, 1903, as an assurance that there is no present or future danger from that disease, inasmuch as complete and harmonious action by all the health authorities concerned is hereby assured, and will be maintained.

GEO. C. PARDEE,
Governor.
M. GARDNER, M. D.,
Representative State Board of Health.
E. E. SCHMITZ,
Mayor, San Francisco.
A. P. O'BRIEN, M. D.,
Health Officer, San Francisco.
A. H. GLENNAN,
Surgeon Public Health and Marine Hospital Service.
ARTHUR R. BRIGGS,
Vice-President California State Board of Trade.
A. A. WATKINS,
President San Francisco Board of Trade.
GEORGE A. NEWHALL,
President San Francisco Chamber of Commerce.
FRANK J. SYMMES,
President Merchants' Association of San Francisco.
GEORGE W. McNEAR,
President Merchants' Exchange of San Francisco.
A. SBARBORO,
Manufacturers and Producers' Association of California.
RUFUS P. JENNINGS,
California Promotion Committee.

That this cooperation is doing very efficient work is not questioned. The results promise as thorough and complete protection as it is possible to secure, and one of the demands of the conference is therefore assured.

It would be fortunate indeed if the turmoil from this question would rest here, but neither the politician nor the newspaper seems willing to submit to so peaceful a settlement. They are now and have always persistently denied the first requirement of this congress. Both the records of this body and the telegrams of Drs. Wyman and Gardner have demanded that—

"It is absolutely necessary that confidence on the part of the health officers toward California authorities should be restored, and I am convinced this can not be done, unless the Governor in some manner acknowledges the presence of plague in Chinatown, San Francisco. Your telegram quoting Governor Pardee's statement in morning's paper, while encouraging and much appreciated, will not, if published in the public health reports, inspire entire confidence in the minds of the health officers, inasmuch as it contains no acknowledgement that plague exists."

"You are authorized, within your discretion, to show this telegram to the Governor, and to urge that both he and the Mayor in some manner admit the presence of plague. It would clear the situation more than any other one thing, and would promptly turn the feeling of resentment into one of confidence."

"The situation now demands absolute frankness on the part of authorities of city and State to prevent pronounced hostile action, particularly when the conference of all the States meets in April."

With such demands upon them, and the necessity for such an acknowledgment before them, it is strange indeed that these factions will not assume a sane attitude in the matter. So late as January 28, Dr. Wyman again urged the authorities of the absolute necessity of this demand, and yet the agreement printed above purely and simply declares that plague exists on the evidence cited, but at no point do the signers give recognition to the fact. They agree to a certain combination of forces, "that the confidence of the Boards of Health of other states and territories may be restored;" "that the danger from bubonic plague may be eradicated;" "that all fears of infection may be removed," but there their adherence ends. It has been argued from these assertions that the truth is herein tacitly admitted, but, if so, what does that amount to, when the facts of any intent of that character are denied. The resolution neither affirms nor denies; but Mr. L. M. King, secretary of the Mercantile Joint Committee, has asserted that Governor Pardee, when he signed this agreement, insisted that he did not wish any one to understand that he (the Governor) intended to convey the idea that plague existed in California. This almost incredible statement unfortunately has been verified by a similar report that no document will ever be officially signed that acknowledges the existence of plague in California. Moreover, four other signers of this agreement have since and have always denied the existence of plague. Mayor Schmitz, after affixing his signature thereto, has, if the newspaper reports are true, continued his denials, and lately has endeavored to reopen his quo warranto proceedings to oust the remnants of the old board, and we were personally assured by Drs. Wyman and Glennan that hereafter no obstructive methods would be practiced by this individual. Hence it is clear that the first object of the conference has not and possibly never will be attained. Another evidence of the insincerity and deception of these various factions is the use, as though authentic, of an intentionally-garbled set of resolutions of this conference, by which the name of J. J. Kinyoun is omitted from the list of bacteriologists. This was unnecessary. Such actions are narrow and ignoble, and will in no way tend to raise California medical matters or politics in the estimation of our neighbors. In conclusion, our duty is plain, and it would be well to heed the handwriting on the wall, and, finally, we would like to ask Surgeon-General Wyman if there was no plague in California on the 19th of January, how does he know that there was none on the 23d of February?

THE MEETING OF THE STATE SOCIETY.

The annual meeting of the Medical Society of the State of California will be held at Santa Barbara, on the 21st, 22d, and 23d of April. It is the natural duty of every regular physician in California to be a member of the State Society, and it is the duty of every member to attend the meetings of this Society.

The meeting this year will be the most important in its history. It is the first that will be held under the new plan of organization, and, owing to the radical changes in the order of procedure, there will be a great amount of work to be done, which is divided into two sections, the house of delegates and the scientific section. The business of the meeting will fall to the care of the delegates from the County Societies, hence it is important for these societies to elect their representatives and see that they attend. The scientific section embraces the reading and discussions of papers, and should attract the greatest number of members. The section on politics is free to all, if you are "in."

The success of any new proposition depends upon the enthusiasm and numbers. The readiness with which nearly every county society in the state has responded to the call for amalgamation is some assurance that the meeting will be unparalleled in members. The program, as heard from, bespeaks an excellent and varied list of papers.

The place of meeting is admirable, not only for its beauty, but because it allows plenty of time for the object of the meeting and sufficient recreation to make the visit one long to be remembered. The most earnest, interesting, and scientific gatherings have been held at points where business interests of a non-professional character have not been allowed to distract the attention.

These, no doubt, are sufficient reasons for attendance, but far weightier ones are found in the recent attacks on medical education and the State Society itself. Both of these have always had enemies, who were ever on the alert, but to-day these factions are united, organized, and better able to do damage than ever in the state's history. Hitherto we have been obliged to meet individuals or small cliques; now the opposition has spies throughout the state, picking flaws wherever any can be found, that the right and position of our Society can be questioned and medical laws be rendered inert and ineffective. There are to-day five bills before the Legislature aiming to undo the present medical law. A society has been organized to lay claim to the title of the State Society. None of the men back of these propositions are in sympathy with the Society, medical education, or the best interests of medicine. Some of them, while working desperately to destroy both institutions, are active members of the State Society. It is therefore necessary for the future of the regular profession of this state that the attendance at the coming meeting be large enough to place the stamp of approval on the Society's work, and that of disapproval on those in and out of her ranks who aim on all occasions to destroy her.

It may be well to remind those who are to read papers and reports that these or copies thereof must be placed in the hands of the Committee on "Scientific Program" at least fifteen days prior to the annual meeting. A careful review of the by-laws by the members will greatly facilitate the carrying out of the program; but, above all, let the attendance be large and the work earnest.

SAN FRANCISCO BOARD OF HEALTH.

On January 8 of this year the term of office of J. M. Williamson, as a member and president of the Board of Health of San Francisco, expired. Immediate and extensive changes were expected, but there was a hitch in the program. Mr. Casey refused to vote according to dictation. The deadlock was maintained for some time, when, through certain influences, Mr. Casey was convinced that the now famous "bubonic" board was honest and had done its duty. As a compromise, he was elected president, and if firmness and honesty of purpose are any criterion, the new president will meet squarely all the demands that are thrown upon him. This move was somewhat unexpected by the politicians, and no more chagrined and disappointed man could be found than Mayor Schmitz, who had concluded that, with Williamson out of the way, his course was clear. It is useless to go into any details in this matter; it is simply a question of political patronage, and what ails the mayor is told by the "Star":—

> The biter bitten, the jobbers "jobbed," was illustrated on Monday last by the election of Michael Casey to the presidency of the Board of Health. The corrupt compact made by Mayor Schmitz with Chief of Police Wittman, that the latter should not be disturbed, if, as a member of the Board of Health, he would do as bidden, has been fully exposed in the "Star." Our readers will remember that Wittman was made the mayor's spokesman in the board, and at its meeting four weeks ago, by direction of the mayor, undertook to tell Casey what he should do and how he should vote. Casey resented his impudence, refused to "obey orders," and spoiled the program so carefully prepared by Ruef and the mayor to elect Dr. Ward president and get complete control of the patronage which the health board has at its disposal. Casey's surprising action caused a "deadlock," as, without his vote, Dr. Ward could not be elected. Every pressure was later brought to bear upon him, but without avail. Schmitz was indignant at his refractory conduct, for had he not appointed him to office? Schmitz can not understand how any of his appointees should dare to question his mighty will, but that Michael Casey should do so was almost too much to bear. He forgets that when Casey was one of the strike leaders, a little more than a year ago, Wittman denounced him and his followers as a "lawless mob," and treated them as such. He forgets that when Eugene E. Schmitz was only a candidate for mayor he promised that "lawless mob" that he would, if elected, remove Wittman and the police commissioners. It was that promise, mainly, which gave him the labor vote. In view of these facts, to not only make the compact to which we have referred, but also to send his orders through Wittman, was too much for Casey, as the election of Casey to be president of the Board of Health by the votes of the very members whom he had removed (coupled with Casey's own vote) is almost too much for Schmitz, who, in an interview, says:—
>
> "Of course, it looks as if Mr. Casey had gone over to the old Board of Health, body and soul. I do not think I was treated with the courtesy that was due me in the selection of a presiding officer. I was not consulted in any way. However, I am of the opinion that, as Mr. Casey is an ex-officio member of the Board of Health, his appointment is not legal."
>
> Was Casey consulted when the mayor entered into the compact with Wittman and Police Commissioner Newhall, by virtue of which Schmitz was to control the Board of Health; Newhall was to be president of the police board; Commissioner Mahoney was not to be reappointed, because he could not be used; Ruef was to have a monopoly of the legal business before the commission; and Casey was to be a figurehead to take orders from Wittman, acting as the mayor's agent? After such a "deal," made cunningly in the dark, such shameful betrayal of the men who elected him, we ask Mayor Schmitz: To what courtesy, sir, are you entitled from any honest man? The cooperation of Casey with the old members of the Board of Health, whom you so outrageously maligned and removed from office (but they did not stay removed), only goes to prove that the whirligig of time makes all things even; that—
>
> "Let Hercules himself do what he may,
> The cat will mew, the dog will have his day."

It is impossible to close these words without reverting to Dr. Williamson. Besides faithfully attending to practice and his duties as Professor of Genito-urinary Surgery in the Medical Department of the University of California, he has several terms on the Board of Health; but none have demanded so great a display of wisdom, conservatism, and courage as his last term of office. No indignity has been too vile, no charge too criminal, nothing, in fact, too degrading for him and his associates; yet his dignity and gentlemanly bearing have never yielded one point to his critics; his course of action has the deserved praise and highest commendation from the local profession. The knowledge that he was maintaining the truth against the greatest odds and temptations fortified him in his position, and the people of San Francisco will yet conclude that he and his board have been their best and stanchest friends.

CORRESPONDENCE.

Just a few words to let you know what I have seen since my stay at Johns Hopkins, which has been very pleasant and profitable. It could not have been otherwise, for every one connected with the institution was kind and hospitable, and all untiring in their endeavors to describe their methods. In the operative service one is impressed at first with the lack of modern operating-room paraphernalia, but upon closer observation it is apparent that this is not essential, on account of one principle which dominates the institution, namely, the distinguishing that which is clean from the unclean. In the gynecological service there are no sterilized nurses at operation, while on the surgical side but one nurse is sterilized. No attention is given to the disinfection of the operating-room or its furniture prior to or during operation. All classes of cases are operated in the same room, whether pus or otherwise. Halsted operates on a plain wooden table, with slightly-elevated sides, upon which rests a board, narrower than the table. This arrangement permits of easy disinfection of patient, with minimum soiling. While this table is not an object of beauty, it is, however, very serviceable. Halsted still uses fine black silk for ligatures. This is rolled on a glass bobbin, which he holds in one hand, tying numerous ligatures without stopping, utilizing the granny knot with an extra tie. He seldom uses catgut, his assistants using it oftener. He does not use silver wire for buried suture as frequently as formerly, for in his experience they occasionally give trouble, acting as foreign bodies under the skin, necessitating their subsequent removal. He, however, buries silver wire in his pus cases whenever the abdomen is closed. Halsted has discarded his original hernia operation, and now does not transplant the cord, but allows it to remain in its bed, frequently not seeing it throughout the operation. If the remote results obtained by this operation are equal to those achieved by the "Bassini" method, then it is ideal, for there is no laceration of tissue, and is easy to perform. The operation is still young, hence has not passed the time limit. The cord is covered with all the structures, brought together anteriorly, excepting at the lower angle of the wound, where an opening is permitted to remain, which provides an exit for the cord. He brings the structures together in three layers, using black silk as suture material, while Finney brings the cremasteric fascia and internal oblique (conjoined tendon) on one side, together with the reflected "Poupart" and cremasteric fascia of the other side, forming a single layer. The aponeurosis is closed with a running catgut suture, formalin catgut being used for buried sutures. Skin is closed with an intracutaneous silver wire suture. Silver foil dressing. Stress is laid upon pressure as a means of preventing the accumulation of blood and serum. This is accomplished by small yucca wood splints laid over the groin, and held in place by a spica of plaster of Paris, which is allowed to remain ten days. Results are nearly ideal, suppuration being the exception, and, as the 100 temperature mark is seldom reached, these results speak for themselves. An important principle, and one which seems to be the keynote to Halsted's work, can best be expressed by the word "hemostasis." In his breast cases, he has three assistants besides himself, occupied clamping vessels, two men who do nothing but hand clamps, one handing ligatures and instruments, a nurse for sponges, an anesthetist, and an extra nurse and an orderly. In one breast operation there were 200 hemostats on the field of operation at one time. Halsted maintains that if perfect hemostasis is observed, time is of secondary importance, this, naturally, under favorable conditions. The axilla is cleaned from above downwards, the axillary vein being cleaned by blunt dissection, no tearing. The finer branches of the vein are caught by the mosquito clamp, a very light and pointed hemostat, which is not apt, on account of its weight, to tear the venules, as is the case so often with the heavier instruments. The wound is brought together with a purse-string of silver wire. Grafting is immediately carried out; plastic operation to close the denuded surface is never performed. Silver foil dressing. Gauze bandages in abundance, but little cotton, plaster Paris bandage, the hand remaining free. After ten days the entire wound is practically healed. Halsted still goes after the supraclavicular glands, when indurated, but does not often invade the mediastinum. Finney's pyloroplasty, has, in my opinion, a good future, as it affords an opening into the intestine from the stomach, permitting the introduction of three fingers or more, a result accomplished by no other method, as far as I have been able to learn. It is based upon the principle of lateral anastomosis, as first advocated by Halsted, all of the sutures being introduced before the bowel is opened. Finney has performed this operation nine times, with but one death (I believe I am correct in these figures), which was due to diabetic coma. This was not unexpected, on account of the grave condition of the patient before the operation. This specimen, which was demonstrated to me by Dr. Finney, presented a perfect line of sutures, with an opening leading from the stomach into the bowel, easily pervious to three fingers. The patient had been operated some time before, and a gastro-intestinal anastomosis made. This opening had contracted so that it was patent only to a probe, a good example of how these intestinal anastomoses contract. Kelly has also discarded silver wire for buried sutures, excepting in his hernia cases, using formalin gut for the fascia. In carcinoma of the uterus, he catheterizes the ureters as before, doing abdominal hysterectomy in all cases. I saw him perform an abdominal hysterectomy by means of the Downes' electric angiotribe, and he seemed pleased with the instrument, but it appeared to the spectator neither easy to use nor easy to apply, for, with all his skill, Kelly was occupied nearly two hours before he succeeded in removing the tumor. The danger of secondary hemorrhage is surely greater than where a firm ligature is applied. Washing out the stomach and a dose of castor oil or Epsom salts, introduced through the tube, is followed out as a routine after abdominal section. Statistics here reveal the fact that there is less post-operative nausea, less flatus, and that the patients experience less difficulty in getting their bowels to move. The procedure is not accompanied with any difficulty, and is easily carried out.

Kelly and Cullen are now occupied in bringing out their new book on "Myoma Uteri," which is to appear shortly. The latter has done a great amount of research on the sarcomatous degeneration of myomata, the publication of which will be hailed with much interest. Cushing's experimental work on the blood pressure in its application to surgical procedures, impressed me as being of great value, with great possibilities. He determines the maximal systolic blood pressure by means of the "Riva Rocci" sphygmomanometer, a portable instrument, its use being based on the principle that the pressure necessary to obliterate the pulse represents the maximal systolic pressure. The pressure is exercised by a rubber cushion placed around the arm, which is connected with a manometer, this being controlled by a rubber bulb. In one case where I saw this instrument used by Cushing, I was much impressed with its value. A man was brought into the clinic suffering from a fracture of the skull and probable intracranial hemorrhage. The blood-pressure readings elicited the fact that the blood pressure was not rising, which indicated that there was no increase in the intracranial pressure, for with an increase in the intracranial pressure there is always an increase in the blood pressure. In consequence of these deductions, it was felt that there was no intracranial hemorrhage. Operation revealed a fracture of the skull, which was elevated, and the speedy convalescence of the patient confirmed the conclusion that there had been no intracranial hemorrhage. Kelly is now utilizing this method in connection with his operative work. During operations a chart of the pulse and blood pressure is kept, these being taken every five minutes, which at once indicates to the operator the exact condition of the patient, a fall in blood pressure and a rise in pulse-rate indicating an unfavorable condition of the patient. This is at once recognized by the operator, who regulates his actions accordingly. Dr. Jos. Erlanger, of San Francisco, who is in the physiological department here, has invented an instrument for determining the diastolic pressure, and which already has proven of the greatest value in experimental work, especially in the domain of pharmacology. In its application to clinical medicine, the possibilities are great, but the subject is so complicated it would not be easy to discuss here. C. G. Levison.

Baltimore, Feb. 10, 1903.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, January, 1903.

The president, D. W. Montgomery, in the chair.

AN END RESULT FIVE YEARS AFTER A PUS JOINT AT THE KNEE.

Dr. H. M. Sherman read a paper with above title, exhibiting the patient.

Dr. Rixford: There is very little that I can say concerning this knee in which Dr. Sherman has secured so excellent a result. It is certainly deserving of some comment. I was reading not long ago in the San Francisco "Medical Press" of 1860 an article by Dr. E. S. Cooper, for whom Cooper College was named. He said that he believed that there is better surgery done on bones and joints in San Francisco than anywhere else in the world, and that he would advance it as a surgical principle that in cases of suppuration of even the large joints proper treatment consists in making bold incisions into them. He ridiculed the old fear of giving entrance of air into joints, saying that it was not well founded.

Dr. Sherman: The scars on this knee are indicative of the openings made for drainage. Voluntary flexion is readily made to nearly a right angle, and extension is complete.

Dr. Wilbur asked: Does the same rule as to fixation hold true in all of these joints?

Dr. Sherman: My only response to Dr. Wilbur's question is, Where you have an infection in the joint, rest should be maintained just as long as the infection is active. Rigidity is the result of infection alone. If you make motion during the stages of activity, you add a traumatism to the infection, and get most serious destruction. After all infection has gone, you have simply the results of the infection. There may be rigidity from osseous union, or there may be close or loose fibrous union; there may be adhesions of the synovial membrane. Perhaps these can be broken down by movement, but that should not be too severe. Anything that will stretch a structure beyond the amount of motion it permits causes traumatism. I learned to be very careful of infected joints by treating a great number of tubercular joints.

LEUKOPLASIA OF TONGUE IN SECONDARY SYPHILIS.

Dr. D. W. Montgomery read the above report, and exhibited the patient. [Published at page 40.]

Dr. G. Gross: First in regard to the leukoplasia: I believe it is not so very rare a condition as is generally supposed. It is unusual in secondary syphilis, but is common in late syphilis. I remember seeing a case in the secondary stage, though it was not so extensive as this one. This danger of salivation is overestimated, and in such a case as this, where the patient has but few teeth, would it not be better to lose all that are left, and later get a new set? In cases in which it is necessary to make a profound impression on the disease, I have found intramuscular injections of the Cheron bichlorid solution most efficient and not painful. I have used it in the dose advised by Cheron, which is 5 cgm. $HgCl_2$ in 20 gm. of normal salt solution. Accidents are rare. As compared to intramuscular injection of calomel, the Cheron solution is less painful and is equally satisfactory.

Dr. Rixford asked: Would not the injection of biniodide oil be preferable to either of these?

Dr. Gross: It is not as powerful or as efficient as calomel or bichlorid.

Dr. Rixford: It has not the disadvantage of the danger, but I have seen it act very quickly, and is not so painful.

Dr. Gross: In regard to the calomel: It is true that it is sometimes very painful, other times not painful at all. I injected two men at the same time; one could hardly walk, and the other kept on riding on his bicycle. There is some danger, though I have never had any accident with it. According to Dieupart, who has made comparative experiments between the two salts, the Cheron solution is just as good as the calomel.

Dr. Montgomery: I did not give this man any calomel injections, because they are so painful and so dangerous. Quite a number of deaths have occurred from them. You can get an embolism from them, and you can get mercurial poisoning, and rapidly, even ending in death. When you inject an insoluble salt, you do not know the dose you are administering. That insoluble salt may be absorbed very rapidly or very slowly. I think, from my reading, that the calomel injections are very powerful just in such cases as this. Fournier says that they are the treatment for the leukoplasia, but the danger from them and the pain have kept me from using them. I did use calomel injections in one case of leukoplasia, but it is an old leukoplasia,—an old syphilitic glossitis,—and I got as good results from inunctions or from calomel, and they were less dangerous, and a great deal less painful. I have never injected a very large amount, like 5 cgm., at one time. I have injected a 1 and 2, but never 5 cgm.

A NEW OPERATION FOR TUBERCULOSIS OF THE ANKLE-JOINT.

Dr. S. J. Hunkin: This is a late operation of mine for tuberculosis of the ankle-joint. Tuberculosis of the ankle-joint begins nearly always in the astragalus, and we have been making arthrectomies and excisions of the astragalus, and we have gotten very good results, but with no motion in the ankle-joint. I have been struck for a long time by the fact that frequently the articular surface of the astragalus was in particularly good condition, i. e., the cartilage would be sound, while the bone underneath was perfectly rotten. This boy came to me some three or four months ago, and, on opening the joint, I found the cartilage smooth. I then opened the astragalus from the sides, and literally scraped it all out, leaving nothing but the cartilages. The cavity filled up, and the wounds here almost healed within a couple of weeks. Now the function is excellent, the form of the ankle is practically normal, and there is no evidence of disease remaining.

Dr. Rixford: It is a very interesting thing. The only criticism I would make is that it is ordinarily unnecessary to cut the tendons behind the outer malleolus in performing resection by Kocher's method. It is perfectly easy after cutting the ligaments to open the joint and throw the inner side of the foot completely against the tibia and draw the tendon back. The sheaths are open, and should afterwards be closed with catgut suture. They unite well enough. There is no great objection to cutting the tendons, but I think it is better not to do so, except where it is necessary. Removal of the focus of disease from the astragalus, if it has not yet invaded the joint, seems to be very rational procedure, and the result in this case is excellent. I showed a case here some six months or a year ago in which I had done the Kocher operation of arthrectomy, but in that case there was, in addition to the focus in the astragalus, considerable disease in the tibia and between the fibula and tibia, which had to be cut out. Moreover, the patient was an adult. It is now two years since the operation, and he is getting a little motion in the ankle-joint. He can walk, ride a bicycle, in fact, do anything but run.

Dr. Sherman: I think Dr. Hunkin's work is in the line of what is best in the treatment of bone tuberculosis. Early diagnosis is the key to the situation, since removal of the minor infection is indicated, instead of waiting until the disease has spread and the amount of tissue involved is so great that wide dissection is necessary. I think a little bit of good fortune attended Dr. Hunkin, in that he was able to remove the whole of the focus in his operation. I find frequently that there is a disseminated tuberculosis through the bone in these cases, so that the whole bone has to be removed. Taking out the astragalus as soon as the diagnosis was made, we got feet that were good; there was, of course, some disability in the beginning, so that braces had to be worn, but they were finally good feet to walk on. I agree with Dr. Rixford about the cutting of the tendons. In Kocher's operation they can generally be pulled out of the way, and the joint exposed without cutting them. Dr. Rixford's case is hardly comparable to this, in that it was an osteoarthritis of tuberculous origin, and Dr. Hunkin's case was simple tuberculosis of the astragalus, without involvement of the joint structures proper.

Dr. S. J. Hunkin: In reply to Dr. Rixford: I do not usually cut the tendons. It is more difficult, however, to dislocate the foot and expose the whole joint if they are not cut. They are readily repaired when cut, and particularly when the astragalus has been removed they may be conveniently shortened, otherwise they would be too long. I first examined the joint. The astragalus was tuberculous throughout, so I removed it all but its articular surfaces. The cavity was mopped out with pure carbolic acid. For fear the joint was not so perfect as it appeared to be, I wiped it out also with pure carbolic acid, and then with alcohol. I drained the joint, and left it open for three or four days. The wound finally closed, in about two weeks. I tried to do this same thing in a man two or three weeks ago, but found the articular cartilages loose, and picked them off with forceps. Of course, the case was entirely different from the others, and required more extensive removal of tissue.

STRONGYLOIDES AND UNCINARIA.

Dr. Philip King Brown reported the following cases of intestinal parasites, and demonstrated the parasites:—

V. M., native of Porto Rico, laborer, aged 18 years. Entered the hospital for headache and general prostration, accompanied by chills. Some diarrhea of one month's standing. Blood examination: No malaria; white blood-corpuscles, 7,600; 10 per cent eosinophiles; hemoglobin, 75 per cent. Examination of the feces showed no ameba, but the parasites of uncinaria, strongyloides intestinalis, and trichocephalus hominis.

E. G., native of Porto Rico, laborer, aged 30. Complained of pains throughout the body. No diarrhea. No particular symptoms referable to stomach. White cells, 7,000; eosinophiles, 5 per cent; hemoglobin, 90 per cent. Stools showed large number of strongyloides larvae and trichocephalus eggs, also eggs taken to be uncinaria eggs, but from which no typical larvae developed during our observation.

J. W., aged 65, American, cook by occupation. Soldier in the South during Civil War, and served also on war vessel, during which time he landed several times in South America, but for hours only. Never had any symptoms referred to abdomen, except bilious headaches with vomiting. Entered the hospital for acute influenza. Hemoglobin, 65 per cent; white cells, 9,400; eosinophiles, 6½ per cent. Feces showed enormous quantities of strongyloides intestinalis larvae, as many as 30 or 40 under every coverslip taken promiscuously from the fecal mass.

Attention is called to the absence of anemia in the uncinaria cases among Porto Ricans, and the absence of particular or serious symptoms referable to the strongyloides and the associated eosinophilia in all of these cases.

Dr. Evans: I have had no experience with strongyloides. Dr. Brown's point, that he does not find anemia in cases of uncinariasis, is contrary to my experience. There is generally very marked anemia. I had one case, and this man had very marked anemia. Red cell count below 2,000,000 at one time; hemoglobin below 50 per cent. Had most intense eosinophilia, up to 38 per cent. I had a more fortunate experience with thymol than Dr. Brown describes. He was given two doses of the drug, containing one gram each. The ova persisting, he was given four one-gram doses about a week later, and some days later four doses of two grams each were given. Had some rather vigorous reaction, and it was necessary to stimulate with strychnia. After this I found no ova. Only two uncinaria were found in the stools. Still he had quite an anemia when he left the hospital, though he gained over 30 pounds; and he promised to come again for blood-counts, but did not do so. There is a good deal of interest in the classification of the worm found in my case, which was the uncinaria Americana. Stiles believes it is not found in the Orient. I neglected, when the man was in the hospital, to get a definite history of his past, other than that he was born in Canada, had lived in Alaska and British Columbia, but had never lived in the Southern states.

FOREIGN BODY NEAR THE ELBOW-JOINT.

Dr. H. M. Sherman: I saw a little boy yesterday who had three weeks ago injured his elbow, and, following the injury, an examination showed a loose body underneath the skin, hard, lying just in front of the epitrochlea. It was supposed that at the time he fell he received some injury to the bone, perhaps a fracture. There was no wound of any kind observed, and no contusion. Palpation of the epitrochlea and bony points failed to show anything beyond this hard, loose body. The fluoroscope did not show any bony fragments or foreign body, though it showed the ends of the diaphragm rounded, as they normally are at the insertion of the epiphyses. As the arm had been up in acute flexion for three weeks, in the efforts to get this loose mass united to its place of origin, full extension was not used. But as the arm was partially extended, a sharp prominence appeared just to the inner side of the joint. Inquiry of the parents brought out the fact that a year ago the child had fallen on the same elbow, and at that time there was a little place, as if he pricked himself. At this time he fell into some sort of a palm. I do not think the child was treated at that time. I communicated with the gentleman who had had charge of the child, and this morning cut down on the mass and got out a large spine from some palm or cactus. The interest is in the fact that a year ago the boy fell into this palm plant, and that the spine remained in the tissue around the elbow-joint for a whole year, causing no inflammation. This foreign body not only remained in the tissue, but kept its position in the immediate neighborhood of the elbow-joint, until it got such a blow by the child's fall three weeks ago as to change its position. From the shape of this foreign body,—sharp at one end and blunt at the other,—you would have expected it to have been pushed along by the movement of the tissues against it.

Dr. Rixford, discussing Dr. Sherman's elbow case: It is a fairly common thing for people to run against sharp points and various bodies, and break them off at the skin, and not be aware of it. A lady friend of mine had a little painful spot in her arm, which bothered her for a number of years. Some accident was responsible for an opening being made there and the extraction of a sliver of wood about 2"x⅛". She had no knowledge of how it got there. Not long ago a man came to the surgical clinic with a painful swelling in the palm of his hand. I could not make a diagnosis, until I felt it was a foreign body. I gave it a little push, and managed to poke through the skin the end of a needle. Referring to the matter of wounds by cactus points, etc.: I had a patient in the County Hospital some years ago, who, while in Arizona, rolled down a hill into a prickly pear. He knew that mercury was used in medicine, so, on account of the great pain, plunged his arm into a pot of quicksilver, and kept rubbing the quicksilver into the arm and legs. Some months after he came to the clinic covered over with apparently syphilitic sores. I opened two or three of these, and scraped them, and was astonished to find globules of metallic mercury scattered about. By a sort of mining operation I was able to gather about a teaspoonful of mercury from his arms and legs. It was remarkable that so much mercury could be encysted without symptoms of mercurial poisoning. However, after the vigorous curetting, the man had a diarrhea, which might have been due to disturbing the mercury.

BOOK REVIEWS.

"The A B C of Photo-Micrography." A practical handbook for beginners. By W. H. Walmsley. 155 pages, 5x7, with 29 photomicrographs by the author. Cloth, $1.25 net. Tenant and Ward, New York. This work is the one needed to fill a total lack of an American book on this interesting subject and to serve as an introduction to a branch too difficult to grasp as presented by the standard works on the subject. In reality, it is the "A B C" of the art, but its very simplicity and lucidity make it the sine qua non of the beginner, who, mayhap, found some insurmountable barrier to success. To such this book is a boon and a necessity. The author is widely known, is a recognized authority in the photomicrographic world, and his varied and extensive experience enable him to express in plain, comprehensive, and excellent diction the ideas intended to be conveyed. The illustrations not only add to the value of the book, but are, in themselves, things of interest and beauty. There are thirteen plates, presenting twenty-eight subjects. The work is admirably printed and excellently bound.

"Biographic Clinics." The origin of the ill health of DeQuincy, Carlyle, Darwin, Huxley, and Browning. By George M. Gould, M. D., editor of "American Medicine," author of "An Illustrated Dictionary of Medicine, Biology," etc., "Borderland Studies," "The Meaning and Method of Life," etc. Philadelphia, P. Blakiston's Son & Co., 1012 Walnut Sreet. Price $1.00 net. 1903. In this work the author has opened for investigation a new field, that of "the patient's life problem, the duty of studying the life as a whole, all of his diseases, past, present, and to come, and what relation they bear to his life and sociologic conditions." The author expresses the belief that such study will be part of the science of medicine in the future. At present it is best carried out by referring to historical data in the lives of prominent characters, as those mentioned in the volume just brought out. The author does not intimate the truths he finds, but proves them to his readers, and they should be many. It is intensely interesting, the style is that of a master in English diction, and the novelty of the theme adds zest. It is to be hoped that the proof of the injury done these eminent characters during life by ignorance of their physical defect will stimulate the students of this book to remember the possibility of such ocular reflex in their cases. Binding and type comport with the matter of the work.